

**MISSING LINKS: COORDINATING FEDERAL
DRUG POLICY FOR WOMEN, INFANTS,
AND CHILDREN**

**HEARING
BEFORE THE
COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
ONE HUNDRED FIRST CONGRESS**

FIRST SESSION

JULY 31, 1989

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MISSING LINKS: COORDINATING FEDERAL DRUG POLICY FOR WOMEN, INFANTS, AND CHILDREN

MONDAY, JULY 31, 1989

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Herbert Kohl, presiding.
Present: Senators Kohl, Levin, and Wilson.

OPENING STATEMENT OF SENATOR KOHL

Senator KOHL. This hearing will come to order.

Today I would like first to thank our distinguished Chairman, Senator Glenn, for encouraging this hearing. Senator Glenn has a long-standing commitment to combatting substance abuse and he has contributed significantly to our national effort.

This morning the Committee on Governmental Affairs will continue its oversight of Federal drug policy by focusing on our most vulnerable citizens, mothers who abuse drugs and alcohol during pregnancy and their tragically exposed infants.

This morning Secretary of Health and Human Services, Louis Sullivan, and Drug Czar, William Bennett, are announcing the results of a new survey showing that overall illegal drug and cocaine use is down dramatically. But the survey also shows that among women of child bearing years, the use of crack is skyrocketing.

The failure to address the abuse of crack by pregnant women and mothers is not news to anyone who knows what is happening in our society, what is happening in our streets and in our hospitals, and what is not happening in our "War on Drugs."

For the past 2 days, the Washington Post has put a face on failure. We read about a mother who went to a newspaper—a newspaper mind you—because she thought that she might be able to get some help if her story was made public. She knew she had not gotten help from Child Protective Services, or the criminal justice system, or the health services or the educational system. All the normal support services had failed here.

In this incredible story, 6-year-old Dooney Waters is quoted as saying, "Drugs have wrecked my mother and if I am not careful, drugs are going to wreck me, too."

There are a lot of reasons for the system failing Dooney Waters and hundreds of others like him. If we do not stop the flow of drugs

across our borders, we surely are not going to stop the flow of crack through our streets.

If we do not coordinate our programs, we cannot integrate our services in ways which will help people. Somehow the Administration can coordinate press conferences so that the news of the day balances out, but it cannot enlist the cooperation of Federal agencies in a comprehensive attack on the drug problem.

We are here today to do three things, to establish the dimensions of the crisis, to talk about why the needs of women and children are different, and to decide what steps must be taken to meet these needs. Unless we pull these programs together, unless we respond to the needs of pregnant women and their infants, unless we deal with this emergency as the public health crisis that it is, the statistics released this morning are going to be nothing but a fading memory by this afternoon.

Look at the facts. At the same time that fewer high school seniors and households are reporting using cocaine, the numbers of addicted mothers and exposed infants in urban and in rural America are soaring. Every 90 seconds somewhere in this country a child is born suffering from exposure to cocaine. From Wisconsin to Washington, D.C., maternal substance abuse, especially with respect to crack cocaine, has reached epidemic proportions. This year alone, more than 375,000 infants are going to be affected.

In my home City of Milwaukee, three to six cocaine babies are born every day and in one Milwaukee hospital 35 percent of all the babies born this year tested positive for cocaine.

And the skyrocketing infant death rate right here in our Nation's capitol, now more than twice the national average, has been tied to maternal cocaine and alcohol abuse.

And how are we responding? Well, this year we are going to spend \$7.5 million in model treatment programs. That, folks, comes to \$10 for each affected mother and child. Of the 135 applications for the Office of Substance Abuse Prevention drug treatment grants for pregnant women and infants, we this year are prepared to fund in a limited way just 20 to 25 programs.

It would take \$35 million to fund all of these treatment programs. And I want you to know, ladies and gentlemen, that the Department of Defense spends \$35 million every single hour.

What has happened to our priorities here? Today's pregnant women can show up at a hospital emergency room for drug treatment and get turned away. She can reach out for help and end up back at the crack house for the last 4 months of her pregnancy. It is no secret that there are waiting lists for treatment in this country everywhere, but it seems to me that providing access to this particular population cannot wait, because these children cannot wait to be born and they cannot wait to grow.

If we fail to address their needs now, then we will have failed miserably. One out of every three substance exposed infants suffers from low birth weight and will need an additional \$30,000 in initial medical care. Furthermore, by the most conservative estimates, it will cost more than \$45,000 for health care, social services and special education to get a newborn exposed to drugs this year ready for kindergarten in 1994.

These costs will not end in kindergarten. Because of the cognitive and behavioral deficits associated with prenatal drug exposure, the potential lifetime earnings of 11 percent of the children born this year will be reduced by at least \$10 billion. Crack and other illicit drugs are ripping away at the hearts of the most innocent in our society, and it is taking away our future along with it.

This morning we will hear from parents, health experts, treatment providers and child welfare officials about the importance of working together to stem this emerging epidemic. We will hear that so many of these problems are related, that parents who are the victims of family violence may turn to drug and alcohol abuse, that children whose mothers cannot get drug treatment may end up in the foster care system, and that mothers afraid of criminal prosecution fail to seek the very prenatal care that could help their babies and them.

Last we will hear from our Federal experts, at least some of them. They will tell us of the barriers to progress, both to terms of funding and coordinating programs.

So I look forward to working with my colleagues to ensure that the emergency posed by maternal substance abuse does not go unanswered. I hope that the answer starts today here with us. Senator Wilson.

OPENING STATEMENT OF SENATOR WILSON

Senator WILSON. Mr. Chairman, thank you. I commend you for not only an excellent statement, but more importantly, for holding this hearing. As you have indicated, the response from society on the problem of maternal substance abuse is long overdue and, in fact, there has been an explosion of attention in recent press stories that reflects the explosion of the problem.

A single statistic gives some idea of what has been happening. I believe that we are going to be hearing later in the day from Dr. Chasnoff, but this statistic from the National Association for Perinatal Addiction, Research and Education I think is truly stunning. About 11 percent of all U.S. newborns, or 375,000 babies, are exposed to drugs during pregnancy annually.

As you pointed out, maternal substance abuse can have truly life long irreversible effects of the most serious kind. Health effects, effects in terms of deficit attention. It is, I think, unnecessary for anyone who has been a casual reader of the newspapers to be told of the suffering that is observed by the physicians and the nurses who have been compelled to treat boarder babies, babies who have been left by their mothers to suffer, literally, the agonies of the damned.

These children display early evidence of serious neurological disorders. They are clearly going through drug withdrawal. The 20 minute high of the mother that produces the 72 hour high in the womb produces the kind of damage that is irreversible in many cases. So, clearly, the focus of this hearing and our efforts must be prevention, compassion for the mother, and in particular, concern for the child. The incredible costs both in human suffering and in tax dollars that are going to result from our failure to address this problem simply cannot be tolerated.

It is estimated that \$13 billion a year represents the initial health care costs, and of course, it is impossible to quantify or to even give any qualitative dimension to the human suffering of the children. It must stop. I think that we are undoubtedly at the beginning of what will be the kind of concerted effort that really must be undertaken. We must make a difference.

I am later today going to be introducing some legislation that takes one approach, an approach that is preventive, that seeks to deal with the phenomenon of these mothers who are in need of help. In short, my bill, the Child Abuse During Pregnancy Prevention Act, is directed at the sort of situation that was recorded in a recent book by Professor Dorris which recounts his own heartbreak with his adopted Native American child whose mother died of alcoholism before the age of 35.

The use of drugs by women during pregnancy is avoidable. However, as is pointed out in a number of efforts, is not easy for them to avoid it. Street wisdom among pregnant women is that the use of crack will hasten labor, make it easier. This is true perhaps in the short term for the mother, but at what an incredible cost to the child.

At a minimum, we must have the sort of outreach that will allow those capable of responding to do so early enough in their pregnancy to turn away from drug use. For many that will be too hard. Therefore for those who actually deliver a drug exposed infant, we are going to have to—with their consent or without it—provide them the kind of rehabilitation that gives us some hope that there will not be the kind of recurrence that I read about last week in the case of a woman named Cheryl who had actually given birth to seven drug exposed infants.

I will just say, Mr. Chairman, that I congratulate you on holding the hearing. We must make the kind of effort through outreach, through preventive education, through mandatory rehabilitation, that will not only allow these mothers to, hopefully, lead a very different kind of life, but at the very least see to it that there is not endless recurrence of this tragedy. Thank you.

Senator KOHL. Thank you, Senator Wilson.

At this time I am pleased to call our first panel of distinguished witnesses to the table. This morning we will hear from Elaina M. Wilcox. Elaina is the mother of three children, is from Philadelphia where she is a client at The Family Center. We are very pleased that Elaina volunteered to come and speak with us this morning. It is certainly not easy to testify about one's own experiences, so we are very grateful to Elaina because we will learn a great deal from what she has to say to us.

Accompanying Elaina is Teresa Hagan. Teresa is Supervisor of Clinical Services at The Family Center. The Family Center is a comprehensive treatment program for mothers abusing drugs and alcohol. The Center has a 20 year track record in treating maternal substance abuse, and so we look forward to learning from their long history and vast experience in this area.

Dr. Reed V. Tuckson is Commissioner of Public Health for the District of Columbia. As the foremost expert in public health here in our Nation's capitol, we are honored to have Dr. Tuckson with us. We are also delighted to have experts from the west coast with

us here this morning, and we thank them for traveling such a long distance to be with us.

Sherry Agnos is the developer of the Phoenix Project in San Francisco, and she is the wife of the mayor of San Francisco. Accompanying Sherry Agnos is Minnie Thomas. Minnie is the director of Mandella House in Oakland, a residential treatment program for crack addicted pregnant women recently featured in Time magazine.

We also look forward to hearing from Dawn Horrell. Dawn is a graduate of Mandella House. As with Elaina, we admire Dawn for her willingness to share her story with us, and we assure you that it will help those of us making policy decisions, as well as all the other mothers out there who are in need of help.

Folks, because we have so many witnesses, I am going to ask everyone to keep remarks down to 3 minutes. Your written testimony will be included in the record in its entirety. So if you can keep your remarks brief, we will have plenty of time for questions and for discussion. Elaina, we will start with you.

TESTIMONY OF ELAINA M. WILCOX, PARENT, ACCOMPANIED BY TERESA HAGAN, SUPERVISOR OF CLINICAL SERVICES, THE FAMILY CENTER, JEFFERSON MEDICAL COLLEGE, PHILADELPHIA, PA¹

Ms. WILCOX. Thank you. Good morning. My name is Elaina Wilcox. I am here because I was asked to come and share some things about myself. I am a recovering addict and I am a parent. I was born and raised in Philadelphia and due to my mother's illness, multiple sclerosis, and my father's abusive behavior to me both physically and sexually, I was filtered through the child welfare system. While in foster care, I went to bed thirsty and hungry more times than I can remember.

Moreover, it was very hard to make friends because I was constantly uprooted. When I was 15 years old, shortly after my mother's death. I started using drugs. Drugs gave me a place in life, even if it was a negative place. Drug users were my friends and family. Drugs deadened my emotional pain. There is so much talk about how drug addicts are. I can tell you that drug addicts are human beings who have the same hopes and dreams that you do.

Drug addicted mothers love their children just like any other mother. I love my children. But it is not easy to stop using drugs. It has taken a long time and a lot of treatment for me to reach this point in my recovery. Recovering from any kind of addiction is a long-term process, fraught with relapse. It takes a tremendous support system. I feel lucky because I have support. I have my children—that means more to me than I can say—and I have a good friend who, with his family, believes in me and my recovery.

I also have The Family Center and my counselor, Pat Branham. Treatment has helped me to recognize how my background has influenced my addiction. I medicated my pain for a very long time. Now I can talk about that pain without running away.

¹ See p. 61 for Ms. Hagan's prepared statement.

Even in recovery, I think you should know that everyday survival is difficult. My three children and I have just moved from a one bedroom apartment to a larger one with two bedrooms. With welfare and food stamps, it is nearly impossible to make ends meet. I can tell you I am good with stretching a dollar, too.

I have had problems getting my 6 year old son into a decent and safe school. I have had to teach him to read and write. I would like to go to work, but I know I cannot afford day care. I have come a long way and I am proud of that, but I know though many times the kinds of daily housing, school and budgetary problems I experience overwhelm other recovering addicts.

If I leave you with anything today, I trust that you will begin to understand that many factors contribute to addiction, and recovery requires treatment that responds to those factors. I also want to leave you with hope. After all, with treatment I am recovering. Thank you.

Senator KOHL. Ms. Hagan?

Ms. HAGAN. Yes, good morning Senator Kohl and members of the Committee, Senator Wilson. My name is Terry Hagan and I am program and clinical coordinator at Thomas Jefferson Hospital in Philadelphia. We are the program that Elaina referred to in her testimony.

We appreciate this opportunity to be able to testify and to explain to you The Family Center approach to treatment and prevention concerning the problems associated with addiction in pregnant women. I have to say this morning, before I begin the body of my testimony, that I do agree with the Department of Health and Human Services on the issue that cocaine abuse is increasing in the population of pregnant women. And I would be willing to bet that they do not know exactly how many there are, because I can tell you that most of our women do not have telephones, and many of them do not have housing.

So I do not think that we can begin to have a handle on what kind of epidemic we have in this country. Please know that because of a lack of the treatment services that we offer at Family Center, and because of a lack of research endeavors, we are faced with a drug addicted population that is running rampant in this country.

What I would like to do is just paint a small portrait of some of the services that we offer, and also expound a little bit on what Elaina has told you about, what kind of lives most addicts tend to lead as they are growing up.

The Family Center is an outpatient voluntary program and we offer two kinds of services. We offer medical services and we offer psychosocial services to pregnant women who are drug and/or alcohol addicted.

This multi-modality program endeavors to facilitate the best possible psychological, sociological and physical outcomes for both mothers and infants. We have a prenatal clinic which is staffed by obstetricians that are specifically trained in addiction in high-risk pregnancy, and we also have a nursery that takes care of the infants when they are going through withdrawal.

Our psychosocial services are educational and clinical. Educational, we teach the women parenting techniques and we also give them AIDS counseling.

Our treatment aims, in terms of the clinical component, are aimed at developing personal resources. This means jobs, this means finding housing, it means clothing, if necessary, and it means food as well.

We also direct the services at improving family and interpersonal relationships, reducing and eliminating socially destructive behavior and facilitating the parental/child bond.

Over the last 20 years we have seen a significant number of our women rehabilitated using this holistic approach to treatment. Moreover, in our methadone-maintained women, we have been able to reduce the incidence of low birth weight from 50 percent to 15 percent. Let me explain to you what that means in terms of social and medical costs. Presently, at Thomas Jefferson Hospital, when we have a 2 pound premature infant, that child is expected to remain hospitalized for approximately 3 months at a cost of \$150,000 for that hospital stay.

Research at Family Center has also resulted in successful treatment protocols for infants undergoing withdrawal. And our research indicates that these infants whose mothers have been maintained on methadone are fine developmentally, neurologically and physically.

Now, Family Center also recognizes, as Elaina has most poignantly described to you, that environmental variables contribute to addictive behaviors. For instance, 2 years ago we did a study which compared a population of drug addicted women with a nonaddicted population of women from the same socioeconomic backgrounds; 83 percent of the women who were drug dependent came from families that were chemically dependent, and three quarters of those were alcoholics, either one or both parents. This is in contrast to 35 percent of the women who were in the nonaddicted population; 70 percent of our drug dependent women experienced early sexual abuse, and this is before the age of 16.

Other problems include higher levels of family conflict, physical violence and lower levels of familial cohesion. Presently, 10 percent of our women are homeless, 50 percent of our women have problems with housing periodically, and other social problems include illiteracy, unemployment, crime, and diseases associated with IV drug use, and please do not forget, diseases associated with poverty.

Treatment has to respond to each and every one of these variables, because they complicate addiction and they complicate recovery. For instance, while methadone may encourage a heroin-free existence and a healthier baby, if we do not answer in treatment the kinds of social problems faced by our clients, methadone does not work either, relapse is imminent. Our cocaine pregnant women are presenting us with corresponding complex social ills that I have just described, as well as the same kinds of medical problems that we used to see 20 years ago in the heroin population.

Due to the complications associated with addiction, we suggest that energies concerned with treatment and prevention need to be directed towards housing and education. Presently we have developed a proposal to house 50 cocaine addicted women and their children. This would provide intensive drug and medical treatment, as well as an extensive educational and drug training component. This would allow us to examine the significance of housing, com-

munity, education and job training on drug use. In addition, we should be able—and this is so important—to influence the development and socialization of the children that would be involved in this housing program. This project could serve to eliminate the medical and social problems experienced by the drug dependent woman and her children.

I do want to underline for this Committee today the debilitating nature and the long range intergenerational effects of chronic drug addiction. It is even more devastating to drug dependent women and their children, who so frequently do not have the kinds of resources for recovery available to them.

Because of the intergenerational transmission of the disease of addiction, as a country we have fostered a spiraling legacy of addicts giving birth to addicts. Must this generation and future generations suffer due to our unwillingness to act with urgency. We must make a sincere commitment that turns the course of this human tragedy.

Thank you.

Senator KOHL. Thank you, Ms. Hagan. Dr. Tuckson.

**TESTIMONY OF REED V. TUCKSON, M.D., M.B.A, COMMISSIONER
OF PUBLIC HEALTH, DISTRICT OF COLUMBIA ¹**

Dr. TUCKSON. Thank you, Senator Kohl. As the Health Commissioner of the District of Columbia, I certainly am impressed that health is the one place where all of the social forces converge to express themselves with the greatest clarity and the most import. The problems of women, children and infants related to substance abuse is certainly a manifestation of a much larger set of issues that occurs in that context.

It also occurs in the context of a health care delivery system that is already woefully unprepared to take care of the health care needs of poor people in regards to heart disease, cancer, chemical dependency, infant mortality, diabetes, and now HIV disease. And so this particular problem, as we look at it, exists and has to be understood in context of all the other things which we are not doing a very good job of either preventing or managing.

There can be no question that the numbers of women who abuse drugs such as crack cocaine and the resultant increase in sexually transmitted disease, HIV disease, infant mortality, disabled and neglected infants and children, has now reached the level of a true public health emergency, and it needs to be treated at that level of urgency and seriousness.

Crack users we know—as you have already talked about the extraordinary addictive potential of that drug—will do almost anything to acquire that drug, particularly women. They will engage in sexual relationships as a means of bartering or financing their habits. Those sexual relationships combined with that stimulus for finances and getting the drugs, combined with the aphrodisiac effects of the drug, of course, now has become the single most important reason for the increase in sexually transmitted diseases that we find in this country, a set of statistics that are getting progres-

¹ See p. 65 for Dr. Tuckson's prepared statement.

sively worse and in and of themselves are an extremely important phenomenon that we will have to deal with in the health community of this country.

We also know though that this has an effect on HIV disease. Cocaine addicts get so high, sir, that they now are turning more and more to using intravenous heroin as a means of coming down. So we are in danger of creating a new generation of female heroin addicts with all of those sequela of complications, not only for HIV disease but, of course, the other general health concerns that we have to be concerned about. In the District, 53 percent of the women who are HIV positive are drug abusers. The overwhelming majority of the rest of them are the sexual partners of IV drug abusers. And I do not know, sir, who is going to be able to take care of the total health consequences of these women, who often and usually are uninsured and often do not fit into some of the other categories of public health insurance programs.

This is going to be an extraordinary burden on health systems which, again, as I remind you, are already underserving the chronic problems that we have always been forced to try to deal with. This increase in sexual behavior, of course, also has the effect of increasing pregnancies. This sexual behavior, of course, is so often unaccompanied with safe sex practices, as we see in HIV disease, and now, of course, the pregnancies.

Every month in this city the ambulances pick up at least 20 women who are pregnant and so compromised by the effects of drugs that they require the services of the emergency medical system of this city. That is an extraordinary burden. You know from published reports that D.C. General, when I made rounds there recently, 45 out of 60 bassinets in the newborn nursery were occupied by women who had abused drugs; 40 percent at Howard University Hospital, 33 percent at Greater Southeast Hospital.

The infant mortality rate, despite all the work that we have done—and we have done a lot of work to lower our infant mortality rate and in fact had lowered it, as you have mentioned in your earlier testimony—now has increased to 23.2, simply and directly as a result of substance abuse.

What I would say to you in the minute or so that remains, I am very encouraged that we have begun a very important dialogue with the Federal Government, especially the senior officials of Health and Human Services. What we remind them is that we have got to coordinate not only around the specific issues of pregnant substance abusers, we have to be concerned about their general health care. We are still not meeting those needs, the needs of nutrition, the needs of HIV disease, hospital based care, developmental disabilities, education, recreation, employment, housing, and other social support services.

If we are going to manage the sequela of the constellation of all these integrated forces, it means we have to look not just at substance abuse for women, infants and children, but the whole perspective in which it occurs. Otherwise we will be missing the boat.

I would say to you, finally, that we certainly need to continue to develop the research base around how to treat the cocaine abuser. We simply have an inadequate database in general, but for women

who are pregnant who therefore cannot use the already developed pharmacological interventions because of its effect on fetuses, we have a long, long way to go. We can bring people into treatment. We can create more slots, but what do we do with them once we get them in there? There is a lot of work that needs to be done there.

In terms of prevention, we are working with the Office of Substance Abuse Prevention to look at what are the best, most cost effective models. There is a great deal more that needs to be explored and developed in that regard. Outreach efforts to women who are abusing drugs, how do we really get at people to try to get them to use safe sex practices, to use those kinds of interventions that will cause us not to continue to spread the virus. And that has to be work done that is done at the level of the crack house, which is happening in most of our communities but needs much more to be supported.

And again, sir, in terms of the treatment systems for those women who are HIV positive, and their babies are HIV positive, we spend a lot of money on prevention, as we should, and on research, but where we do not have the money is to support public health systems that are already overburdened trying to meet a traditional mandate and certainly are not prepared, financially or labor intensively, to manage these new problems.

We also have to look much more at infant mortality around our ability to do case management. As you understand well, there are so many elements in these persons' lives that have to be coordinated. We do not have a case management system in place in urban America to be able to manage that. We have to be able to go into the home and do home visitations to be able to help on that one on one individual real life level. The resources have to get down to that level of specificity and intensity.

We also have to—and I will conclude by saying—be very concerned about the babies that are going to be born who are developmentally disabled and getting them ready to go into the school system. As you indicated, we are going to be paying for this for generations and generations, the consequences of this, and we are going to have to deal with it.

Finally, we are going to have to help and encourage our community based institutions, our churches, our civil associations and individual citizens to come forward and care about the foster care needs of the babies that are being born to these substance abusing women. The boarder baby problem is extraordinary, it will require a very real commitment of American people to just simply say that as an American in this day and age the definition of being a civilized patriot cannot be that we would allow babies to live and die in hospitals in these cold and lonely places, but people have to come and adopt them and care for them. And I think that that gives us an opportunity as Americans to express ourselves.

Thank you, sir.

Senator KOHL. Thank you, Dr. Tuckson. Ms. Agnos.

TESTIMONY OF SHERRY AGNOS, DEVELOPER OF PHOENIX PROJECT, SAN FRANCISCO, CA; ACCOMPANIED BY MINNIE THOMAS, DIRECTOR OF MANDELLA HOUSE, OAKLAND, CA; AND DAWN HORRELL, GRADUATE OF MANDELLA HOUSE, OAKLAND, CA

Ms. AGNOS. Senator Kohl, Senator Wilson, I am very pleased and honored to be here with you today to discuss with you San Francisco's plans for the Phoenix House project. San Francisco, like most other urban areas and many rural communities, is struggling to come up with solutions to the crack cocaine epidemic. More than 700 drug exposed infants will be born this year alone in San Francisco. That represents 7 percent of all births city wide. Eighteen percent of all babies born at San Francisco General Hospital test positive for crack cocaine. Of those 700 plus drug exposed babies, 85 percent will have mothers who used crack cocaine, many of them in conjunction with other alcohol and other addictive substances.

A staggering 76 percent of the cases in our foster care system report substance abuse as the major factor. It is difficult really to estimate the average cost per infant born to drug addicted women. Between 20 to 40 percent of the crack addicted pregnant women have premature deliveries. The total cost of care in the neonatal unit at San Francisco General Hospital for some of these premature deliveries can cost as much as \$200,000 per birth. And that, as you have heard already, is only the beginning of the cost.

In San Francisco, the first generation of babies born to crack addicted mothers are now entering kindergarten. I have personally talked to many teachers and counselors who report that they have never seen such vast numbers of developmentally disabled children entering our public schools as they are presently experiencing.

No one has a real clear solution to all of this. We literally need to invent new social and medical models to solve this epidemic. One invention we know works is a program aimed at capitalizing on the profound maternal instincts of many of these mothers. I actually became interested in this project when I learned that our welfare department had been receiving calls from women who said, I am pregnant, I am addicted to crack, but I want to have a healthy baby, is there any place I can go to get away from these drugs?

Currently, San Francisco has no residential treatment center for pregnant women, so in collaboration with Catholic Charities and funding from a variety of city, state and Federal sources, I am developing the Phoenix Project, which will be the first comprehensive treatment facility in San Francisco that will accommodate pregnant women who are motivated to overcome their crack addiction along with their children.

My goal is to raise \$1 million from private sources to purchase and rehabilitate a building which will house up to 15 women and their children. In San Francisco we have a unique problem with the cost of real estate and we really feel that in order to control our operating costs, we really need to purchase a building outright and then come up with the city, state, and Federal funding sources for the operating expenses.

The Phoenix House will provide a comprehensive, integrated program, including substance abuse treatment, medical care, including prenatal, postpartum and pediatric services, job training, child care and parenting classes. All services except hospital care will be provided on-site in a safe, drug free, nurturing environment.

Since an addicted woman's life is usually chaotic, she will follow a structured, daily routine with clearly defined responsibilities. Phoenix House will help her build the skills necessary to be a nurturing parent, leading an ordered and productive life. Many of the life skills which we take for granted have to be relearned, including money and household management, shopping, cooking, nutrition, and especially parenting.

The final phase of the Phoenix House program is job training and preparation for reentry into the community. By coordinating with the state funded welfare reform program, which we call GAIN, the women will learn vocational skills and, if needed, a high school equivalence degree. Phoenix House will assist them in obtaining housing and employment and building support within the community so they can remain clean and sober after leaving the program.

A critical link in sustaining motivation and achieving long term success is maintaining the mother's relationship with her children. At Phoenix House, not only will children live with their mothers as they progress through treatment, a separate program especially designed for them will enable us to intervene in their young lives to create a sense of normalcy and stability.

I know that this all sounds very generous, but Phoenix House is not a handout, it is an investment. And the returns are generous, too. Although putting these programs in place will be expensive, it is not nearly as expensive as not doing anything.

Mr. Chairman, I think that the following statistic really points up the need to focus on preventive care. One day in Phoenix House would cost \$50 to \$70, compared with \$1,500 a day in the neonatal intensive care unit, \$600 a day in a hospital nursery, or even \$92 a day in a very cost-effective foster care program.

San Francisco created a world model to confront the AIDS epidemic that includes community involvement, straightforward prevention education, public/private partnerships, and early medical intervention, and it has paid off. AIDS costs per capita in San Francisco are far lower than anywhere else in the United States.

We can do the same with crack cocaine if we are given the support we need. The city cannot do it alone. We need the financial resources of the Federal Government. We must not delay because it will cost us precious lives. We must focus on every form of preventive program, and this is one we know works.

I have with me today two people who have proven it. My partners today are from San Francisco's neighbor, the City of Oakland. Minnie Thomas is the founder and director of the Mandella House, the first residential drug treatment center for pregnant women and the inspiration for Phoenix House. She has been a wonderful source of information and guidance to me.

With her is Dawn Horrell, a graduate of this successful treatment program. Thank you.

Senator KOHL. Thank you, Ms. Agnos. Ms. Thomas?

Ms. THOMAS. Good morning. I am glad to be here today to talk about this crack cocaine epidemic, because it upsets me that I am dealing with something that is stronger than any drug that has been put on the market before. It scares me because I live in a neighborhood where in three blocks to the main street I can buy at least four or five times if I wanted to. It is being sold across the back fence, and around the corner, and at the bus stop, and at the hospital. And it is being sold where the food stamps are being given out, and at the welfare building. I want to read something that I read to the crack cocaine conference that I attended a week ago.

Our future generation is in crisis today. Crack cocaine is the most devastating drug disaster to hit our families since drug use and abuse began. Our children are being introduced to drugs in utero during pregnancy, after birth, toddlers to teenage and even beyond that. Our men are using crack and introducing it to our moms, and she, in turn, introduces it to her unborn infant.

The use does not stop there. The mom continues to use after the infant is born and the infant turns toddler stage and is dragged from place to place as she seeks out her drugs. The child is often left with the dope dealer until she can raise the funds to pay for crack, gotten on credit. As the child grows older, he sets out not only to feed himself, he hustles funds to give to mom to buy her crack cocaine. At the age of 11, 12 he is dealing in the drug, and from 15 to 20 and beyond he kills to preserve his turf.

The statistics show that the death rate of black men between the ages of 15 and 22 has risen to tremendous proportion in the last 5 years. Where will this all end? What can we do? Where do we start? Who needs to know, and why? What are some concrete solutions? And what do the experts report?

I have created a program, and this program deals not only with the crack cocaine mom, but it deals with the newborn. We take in women that are pregnant. The uniqueness of the program is that we deal with criminal lifestyle, because they come from all walks of life. We deal with drug treatment and child development. The babies that are born in the house stay in the house until the mom leaves. She stays in the house from a year to 18 months, and she has to make the commitment. And all commitments are voluntary. We do not force anybody to stay, but we do not put anybody out. The door is always open if they choose to walk.

What I have come up with in my mind was that we overlook simple things such as reality treatment. Reality treatment means that if you are going to hold down a full-time job, you need to be programed in that way. That means get up at 6 o'clock in the morning. You have got certain things to do. You have got your breakfast to fix and your house to clean and baby to clean and you are ready to go at a certain time.

So we have classes that go on all day from 9 to 3 in the afternoon, and that is so that she can get in the habit of getting up and doing things. We keep her busy, we set her up with outside resources. We teach her time management. What I have seen with women that have come through this program is that their lives are out of order, that they do not have it together. They are not able to make decisions, and if they are, they are not wise decisions.

We have to let them know that it is all right to not do everything at once. It seems that they are confused about how life should go. We are programming them for a year in an orderly fashion. Time management is something that we push.

One thing I have found out in dealing with these moms and bringing this woman in and putting her in a safe environment and feeding her three nutritious meals a day is that the outcome of the babies change. My last baby was 8 pounds and 2 ounces. So that means that we do not have the small head. I have at least 15 babies to come through since December 1987 and the low birth weight is not a problem in that house.

The developmental problems are lessened quite a bit. I have only had one medically fragile child, and the mom has come back 3 weeks ago and showed me that that baby is—other than obvious things, there is no problem with these children that are being born in that house. And that means that we are taking time with that baby, we are taking time with that mom, we are not letting her live with the guilt of bearing this baby. We are letting her know what the damage is that she has done and how to cope with it. We are letting her know that we are her support system as long as she needs us. We are also letting her know that there are support systems out there for her, and we bring them in.

For the first 6 months we do not allow these women in the streets, period, unless we accompany them. That means that any place she goes, we have to go. When we first created the program, we decided that the medical stuff, the welfare and all this stuff, they had to go. We found out that the dealer was everywhere. That means that we must accompany them to pick up even the food stamps. We know that we must accompany them even after they get to the point where they are going out to school. They need somebody to make them feel that they are strong enough to say to the dope man more than just no, but not to take it when it is given.

So I think that we are treating the mental, physical and spiritual side. To leave out the spiritual side, you might as well leave out the whole thing. I found out a phenomenon. I went to the assembly and I talked to some of the assembly women there and the phenomenon was that these women want a bible in their hand. They are talking about God. They also know that this drug is so strong that the whole body takes on a different shape just talking about it. The treatment AA and NA is no longer adequate. It has to include some things that if you talk about cocaine, the effects it has on a cocaine user is devastating. I mean, it can cause them to go out and want to use again. These are the stories that I hear from these women.

And in dealing with this in the last couple of years, I went inside of my head and thought about what am I treating here, what is this? And I came up with this.

She's a mother, and that means something. Trial and error is the name of the game, but love is for real and that is what this is. Love that knows no reason or boundaries, love that hides all faults and covers a multitude of sin. Love in its truest form is the love of a mother for her child.

Who is to say she is good or bad. Are you free of guilt? Have you been had? Sure, we all have, but will that stop us? No, we are

mothers still. We are loving, caring, forgiving, fighting, scolding, struggling but we are not all bad. We have just become a product of the environment, overwhelmed with life's perils, running away, and that is sad, to what? Drugs? Yes, that is it, but not all. Don't you understand? It is too much. We need help.

I am a mother and I have given up. But you could help. How? Just love me, support me, stand by me as I try to be what you expect of me. And I know I can be, I am a mother. I love, I feel and I cry. But the pain is too great. I can't be what I need to be by myself. I am just a mother. No one taught me my role. Trial and error, that is me. Help me to be what I need to be, what I want to be. I am willing, but help me. I am a mother. Dawn Horrell.

Senator KOHL. Thank you. Ms. Horrell.

Ms. HORRELL. Thank you. I am very honored to be here. I definitely do have something to say about this epidemic that is going on. My name is Dawn Horrell and I am a graduate of the Mandella House, which has truly helped me in my recovery.

I was born in Oakland, California. My mother is an alcoholic and a crack addict, my father is an alcoholic and heroin addict. I am not blaming my addiction on them. Although I lived in this household, I was a very strong willed child and I got straight A's all through school. I attended UC-Berkeley in special different programs while I was in high school. At the age of 18 I got a good job at the Oakland Police Department making \$30,000 a year. Then I was introduced to crack. I lost my job, I lost my nice apartment, my brand new car. I lost everything, all my furniture. I just sold it for crack.

I have lived in a rock house with my mother. Me and my mother smoked crack together, we fought together with fists for crack. This is a very powerful drug we are dealing with. I was an addict—I still am an addict—but I was a practicing addict for 3 years, 3 years of my life that I was just walking dead.

Before I knew of Mandella House, I was homeless, drug addicted and pregnant. I went to jail from doing various crimes for trying to get crack. I was in jail 2 months and I heard about Minnie's program from my probation officer. I wrote her several letters. She had to take me. I knew that she only had six beds, and I knew about all these different women that were out there, that I had to get in this program, and it was going to be hard.

God blessed me and he sent me to Minnie and Minnie to me, and there I got the shelter that I needed from the drug, where I can think again and, you know, get back to being my own self again. My mind was made up. I had to stop this madness. I knew that I am too smart of a person, I can't just let this drug keep me down. So I had to come out of it, and I did. And I am still fighting and struggling to stay out of it. I have been out of the program now 8 months and I am still clean and sober and I plan on being that way for the rest of my life.

But it is not easy. It is hard. You know, I see it everywhere I go. Everywhere I go it is there, it is right there staring me in my face. I am still tempted, even to this day, to go buy a hit, and I haven't had one in 20 months—almost 2 years—and I am still tempted.

But my baby—although it wasn't my baby that caused me to stop using drugs—at first I used to say it was, I was going to stop be-

cause of my baby, because, you know, for him. Then I realized I had to stop for myself before I could stop for him. So I wanted my baby, I love my baby and I was devastated. Before Minnie got me from jail, I was pregnant. I was like 8½ months pregnant, I was due to have the baby any day. And if I wouldn't have gotten into the program before I had him, they would have took my baby. Who would have cared for him for me? My mother was a crack addict. She was out there in the street somewhere. My grandmother and everybody, they are too busy. I didn't have anybody to come get the baby, nobody would have come. He would have been in a foster home and no telling where he would be now.

And it would have just devastated me to sit in the hospital and have a baby and then they take him from me and take me back to jail. So I prayed, I prayed. And this is what brought me through, was prayer and God. This is what gave me hope. And God allowed me to have that baby 3 weeks late until I got into the program and therefore I was able to keep the baby. So I realized I had another chance. God had given me another chance and I was not going to fail this time.

Before I left Mandella House—I was there for a year—before I left there, I had completed all my goals that I had when I came through that door, which was, one was to get a job making a good amount of money, at least \$10 an hour, doing something to help somebody like myself. Right now I am working for Asian Youth Substance Abuse Program, which is funded by the Office of Substance Abuse Prevention, which is a program that is helping Asian youth that are at high risk of using drugs.

And so I had my job and also I had an apartment, a two bedroom apartment out of the environment of Oakland, nice. But it is still not easy for a single mother. I am also trying to go to school. I am going to school now, taking psychology. I want a Ph.D in psychology. I want to be a doctor, I want my private practice. I want to help somebody. I want to help these kids that are out there that their mothers are using and abusing them. What can they do? They are just helpless.

I haven't forgotten where I came from. I know that even today if I take that one hit I can go right back to where I came from, right back out there. I will lose the baby, I will lose everything I got all over again. It can happen in one day with just one hit. Right now I am just taking it one day at a time. I just know that something does indeed need to be done about this problem that is out there. It is very drastic. I was out there with it and I know. Something needs to be done.

Senator KOHL. Thank you, Ms. Horrell. I will keep my questions brief so we can go to Senator Wilson.

Once a woman is using drugs, how can we reach her and what caused to you to seek help, Elaina?

Ms. WILCOX. When I found out that I was pregnant, I had been on another clinic methadone treatment and I was transferred to Family Center, which, in Philadelphia is the only facility that deals with pregnant women. And I truly believe if it wasn't for the guidance and the care from the counselors and the staff at Family Center, I would not have had the easy time that I did getting my

life together and gaining the strength to go on to face the problems that come with being a mother, with raising children.

Senator KOHL. Thank you. Ms. Hagan, some people say that the only way to get some pregnant women to stop using drugs is by putting them in jail. What is your response to that, Ms. Hagan?

Ms. HAGAN. We do not have room for everyone in jail at this point. That is one of my responses. But my second response is that is not a treatment method. That it is totally avoiding the issue of what this large problem is about. It's about poverty, it's about lack of hope, it's about lack of education, it's about all of those things. And jailing someone does not even address those things.

Senator KOHL. The Family Center has been providing treatment for drug addicted mothers for 20 years. Why are there so few other programs of the kind that you have been successfully providing for this long period of time?

Ms. HAGAN. Well, I have to say it is a credit to Dr. Finnegan. She is tired. She has been in this for 20 years and without her getting funding for us, we would not be there for these women. As a matter of fact, 2 years ago we almost lost Family Center, and Dr. Finnegan went out and got the funds to get us going again and to get a larger staff to meet the needs that our clients are facing.

Senator KOHL. The Washington Post article yesterday and today, have you read them or, part of them?

Ms. HAGAN. I am sorry, I haven't.

Senator KOHL. Okay, thank you very much.

Dr. Tuckson, what would it take to turn the recent short jump in the District's infant death rate around?

Dr. TUCKSON. It is going take a combined, multi-phased approach. We are certainly going to have to find a way of dealing with the women who are abusing crack cocaine. We are going to have to, at a fundamental level, try to understand better the social conditions out of which that need to take those drugs arises. This sense of empowerment, this sense of giving our young women and men some sense of the concept of the possibility of a future that therefore will give them some reason to take the advice and education that we are giving them.

To do it, we are also going to have to put a worker now at the hospital so that every time a woman delivers a baby, and is pregnant, we are going to have to get that woman enlisted immediately, while she is still a patient in the hospital, into the drug treatment system of our city. We are going to have to take a worker now and follow those women who are pregnant in their homes, literally in a van. We have learned a lot from a program we have called the Maternity Outreach Mobile where we literally drive to the individual's door. If you won't come to us for care, we will bring the care to you, put you in a van and drive you to the clinic.

That is an extraordinary degree of public involvement, one that may be inappropriate in the long run, but for the short run we have no choice but to now do these sorts of exercises and activities.

And finally, sir, we are going to have to be able to create more treatment slots in our drug abuse system for the pregnant woman, now allowing dedicated beds just for the detoxification of the pregnant woman, specific programs and counseling sessions just for them. Even though we have at times a waiting list, we will now—

we have already done this—to now make the pregnant substance abuser the priority for the system. It is those kinds of things.

Senator KOHL. In yesterday's Washington Post, Charles Krauthheimer remarked on the fact that DC has made free prenatal care available but very few women have taken advantage of it. Do you have a comment and a response to that?

Dr. TUCKSON. The observation is correct. Any woman that makes—no matter what your income—you can get free prenatal care in our clinics scattered across the city. But we have seen the people that we need to reach the most are not coming in for that care. I though, as the Health Commissioner, cannot just simply say, well we have done this, we have extended the hours, we have made the access easier, I have done my job, now it is therefore the fault of the individual.

The responsibility now is that Government will have to take the next step, which means to go and bridge that chasm between us and the community, that we now will drive up to your door. If you miss an appointment, we will come and knock on your door and say, excuse me, ma'am, but you had an appointment yesterday and you missed it, now, why don't you get in the van and we are going back to the clinic.

It is going to take that level of intervention for us as well. And I think that we cannot twiddle our thumbs and say, we are here and no one came, we have done our part. No, our part now is more extensive, more involved.

Senator KOHL. Thank you. Ms. Agnos, how important will public private partnerships be in establishing comprehensive treatment programs for drug dependent pregnant women?

Ms. AGNOS. I think they are going to be extremely important because, as I have said before, the city really cannot afford to do it alone. And we have developed very successful public/private partnerships in developing the AIDS model, and I think similarly, in developing a continuum of care that we will have to develop for the crack cocaine use. It is going to have to include public/private partnerships.

I would just like to comment that the businessmen, the corporate world, the foundations have been extremely responsive to the Phoenix Project effort. Just several weeks ago I was at a luncheon of 10 business men and I walked away with \$60,000 because they were just—they felt like this was probably the most worthwhile cause that they could contribute to. And I just hope to replicate those kinds of successful meetings in order to raise the funds necessary.

Senator KOHL. Is maternal substance abuse a public health emergency in the City of San Francisco?

Ms. AGNOS. Absolutely. As I said, we have 700 drug exposed babies born every year, and this project that I am developing will take care of 15 women. So we have a huge headway that we need to make, and it will require the efforts of both the Federal Government and private and public funding.

Senator KOHL. Thank you. Ms. Thomas, do you have a waiting list for women to get into Mandella House?

Ms. THOMAS. Yes, I do, 60 strong, and that is deleting women that have already had their babies, usually.

Senator KOHL. I understand that you are hoping to get a large building to house a new program for drug addicted pregnant women where they will be able to take college courses, is that right?

Ms. THOMAS. Not necessarily college courses. I wanted to include the drop-in center, the treatment mode and the transition housing. That is the three steps that need to be taken. For the women that there are no beds, they need to be able to drop in and get some help. And then there is the treatment mode, which would last a year. And then we are talking about transition, which, it is not really profitable, or healthy even, to let these women stay in a program for tie year to 18 months and then turn them back into the same situation they just came out of.

I am hoping for county collaboration, that is what I am working with at this point. I am trying to get—we have a lot of resources in all our counties—you know, there are nurses needed, the pediatrician, the midwife, the psychologist. All of these people are already there, all they have to do is make house calls into these programs, and that is very much a part of the healing process.

Senator KOHL. If Federal buildings were made available, would that be helpful?

Ms. THOMAS. Yes, it would. I mean, the more space, the better it is going to be. Right now I have six beds. And when I say six beds, I am excluding my babies, so we got actually 12 beds, six moms and six newborns. And that is pitiful. You know, we get women crying on the phone saying, if you do not have a bed, what am I going to do? Can't I sleep on the couch? I mean, they are asking for help. We need treatment centers.

And I think the collaboration of the counties with buildings and with funds and making funds easier access, we really need to access those funds. I cannot write a proposal, you know, and so where this money might come down, if I do not have in my budget a place to hire someone to write this proposal, I could miss the money.

Do you see what I am saying? So we need access.

Senator KOHL. Thank you. Ms. Horrell, so much of the emphasis on the Federal war on drugs is on law enforcement. You yourself were a police dispatcher when you ran into problems.

Where should those of us in Congress be placing our priorities and how much attention should we pay to encouraging programs like Mandella House?

Ms. HORRELL. You should be placing your attention on the drug epidemic, itself, because it is the drug that is causing all these problems, the drug that is causing most of the crimes. I was in jail myself and they say 80 percent of the people in jail are drug addicted or drug affiliated, but I say it is 99.9 percent was affiliated with drugs some type of way, and that is what is causing all the crimes.

What needs to be done is there needs to be more treatment programs. Because without that treatment program, I would have lost my baby. I would have had him in jail, lost my baby. When I would have got out of jail 6 months later, what did I have to live for? I already lost my baby, I might as well go back to smoking. I didn't have anything else to do. So it was that drug treatment program that really helped me recover, and I am proof that there is hope. I

came out of it. I am a strong person, you have to be a strong person in order to come out of it. You cannot be a weakling. You have to really make up in your mind that this is what you want to do and this is what you are going to do.

But the treatment program that I was in helped me to make that decision. Without it, I probably couldn't have made that decision. I needed that support, and I needed that someone that cared. I didn't have anyone that cared, and without that, what did you have to live for? And a lot of these women out here, they do not have anybody that cares. Their family, they disown them, they do not talk to them any more. They go to jail and they just forget about them. And they come out and all they know is the street people that they were out there with. That is all they know, and so that is all they have to go back to.

Senator KOHL. Thank you. Senator Wilson.

Senator WILSON. Thank you very much, Mr. Chairman. Let me say that I have great admiration for members of this panel. Each in their different way has made, I think, a great contribution this morning.

Let me just ask a couple of questions. Before I do, I am struck with what seems to me one fundamental truth. Ms. Agnos made the comment that however expensive these programs are, the alternative of failing to respond is infinitely more expensive. That is true just in terms of tax dollars, not to mention the incalculable human suffering that is involved.

Let me ask Ms. Hagan and Dr. Tuckson this question. Let's assume that an aggressive outreach program is in effect, that there is an appeal being made in a variety of ways to reach the young mother who upon learning that she is pregnant and knowing that she is using, will, if she responds, have an opportunity voluntarily to come in for treatment. Indeed, in Ms. Agnos' testimony she mentioned that it is not uncommon for drug using women when discovering that they are pregnant do in fact call, do seek to—at least during the period of the pregnancy—come forward to clean themselves up so that the child will not be injured.

What, in your judgment, if there were an aggressive outreach program, would be the impact? At what point in a pregnancy is it not too late to avoid damage to the fetus?

Dr. TUCKSON. Well, first of all, from a treatment perspective, it can never be too late. Of course, we would rather start from the day one. The first trimester of pregnancy when the developing fetus is developing all the vital organs and the very complex development is occurring is an extraordinarily important place to try to prevent having any kind of a toxin introduced into that system. And that it is a vital area.

But equally important, there are some very complex and very sensitive events that occur around the process of labor and delivery, and so that we would certainly not want to have the added compromise of these toxins introduced at that point as well. So my answer, I guess, to you, sir, would be that optimally we want to prevent it from the very beginning. But just because the person is already doing it and hasn't gotten adequate prenatal care, we still need very much to make sure that this is a drug free environment at the time of labor and delivery at the very end of the process.

Senator WILSON. What is your experience, Ms. Hagan and Dr. Tuckson, in terms of people being able to come in voluntarily? Ms. Horrell has been most eloquent this morning. It is tough. She is tempted, and she has a strong character. She is strong willed. Yet, she is still tempted after 20 months.

How realistic is it for us to believe that we will be able to appeal successfully and bring drug abusing pregnant women in? So powerful is the grip of addiction that it leaves many of them really unable to fulfill their maternal instinct.

Dr. TUCKSON. Certainly there are a couple of variables here. There are many women who in fact can be convinced of the importance of coming in, that realize that they have a problem. The people that are abusing drugs very often, again, are not people that are enjoying themselves. These are not happy people who are just off being irresponsible. These are people that are suffering.

If you can make the treatment system available, easily accessible, that becomes the first dimension. But again, as we mentioned, the problems of women who are abusing drugs occurs in the larger constellation of men who abuse drugs, and so many other people that abuse drugs, and so the treatment slots are already taken up by the people that are ahead of them in line.

So let's say we could fight through that problem and create more spaces. Then the question is, can we make the treatment service sensitive to that woman, sensitive to the needs? Let's say the woman already has other children. When she comes to the clinic and brings those other children with her, is there a place for someone to care for those children that so, in fact, it is not a burden or hassle trying to get to the clinic?

What are the hours the clinic is open? Let's say that the person is abusing drugs and somehow is still able to find a way to work. Does the clinic close at the same time the job closes? What about on Saturdays, what is available then when people need help? So how do you make those things accessible there?

Then it comes to the kind of care that we give. What is the character and nature of that care? Are we giving that care in a way that is empathetic enough so that we encourage the participation? Do we give the incentive for the woman to come back tomorrow or the next day, or do we put burdens and disincentives for people being involved in the system?

Those are all variables that have to be addressed in answering your question.

Senator WILSON. Is your program one of outpatient care rather than resident?

Dr. TUCKSON. We in the District primarily have outpatient care, and one of the deficiencies in our system, sir, to be frank, is that we don't have enough inpatient care.

The inpatient care is a problem. In most communities in our country, unfortunately as American people, we have wonderful ideals and we give great rhetoric. But not in my neighborhood do I want this to exist and to live.

For so many issues, "not in my back yard" is the refrain in other communities. And then, if you imagine, that is for certain kinds of programs. Can you imagine having a program like this that has

self-proclaimed substance abusers in your backyard and neighborhood? So that becomes a real problem.

And then there are, of course, the cost considerations. It is a very labor intensive exercise. The kinds of programs like Mandella House, which are cost-effective, but they still require up-front monies. In communities like the District of Columbia where the real estate prices are very, very high there is a certain capital cost that is extraordinary.

Those are some of the barriers. So no, we do not have enough of those and we have to overcome these obstacles of community acceptance and finance if we are going to be able to solve it. Ultimately, sir, I would say to you that if we as an American people are going to suggest there is a war on drugs, that war is going to have to involve all of us. And some people have not been a part of the process. And being a part of the process may be nothing more than not being an obstacle to siting and locating an outpatient or inpatient drug abuse facility.

Senator WILSON. Let me just ask, doctor, in light of the kind of program at Mandella House where there is a residential setting and round-the-clock observation and companionship, where Ms. Thomas does not allow someone to go to the welfare office unaccompanied for fear of their being hit on by the dealers, isn't comprehensive residential treatment required?

I guess I would ask you, Ms. Horrell. Do you think that it is possible for someone—given the compulsion and the temptation which even now you say you feel—is it possible to recover, to kick your habit, in a setting other than one like Mandella House where you have this 24 hour environment?

Ms. HORRELL. It is probably possible, but like I said, it was hard for me even in the program, and I am a strong person. Just imagine those people out there that are not strong and just imagine them not even in a program, trying to recover. It is very hard. I tried before I went to the program, and even me being strong, I tried and I could not do it. I couldn't do it. It was impossible for me, but I know it is possible for someone. I know that someone has done it. I don't know who.

Senator WILSON. Most of the people who come to you, Ms. Thomas, are referred by the courts, by county protective services, or county agencies.

Ms. THOMAS. Correct, but not just exclusively. They come from walk-ins, from word of mouth. They come from the hospitals.

Senator WILSON. So the women at Mandela House both voluntarily commit themselves and some are involuntarily sent by the agencies?

Ms. THOMAS. They are all voluntary. If the woman writes to me from the jail, I approach the judge. She might be already sentenced. I might say—well, I did say to him for her, I said, she is a person that I would like to give a try, I would like to see can I help her, I believe she is sincere in saying that she will accept the support. And he modified her sentence and placed her in the program.

Do you see what I am saying? So it was still voluntary. It wasn't like she was mandated. They do not just mandate people to my program. I put them through a certain protocol of interviewing. And just to tell you the truth, it is intuition that has me accepting those

six people to come through that door when I have got 60 to 90 calls having to decide.

Ms. HAGAN. Excuse me, Senator Wilson. Our mandated women do less well in the program than women who are voluntary, if that helps you with what you are searching for.

Senator WILSON. Well, I am sure that is true. That just makes sense. On the other hand, I think the point that we must face is that we have got a population that includes both. And I take it that in your experience in Philadelphia you have both. Is yours an outpatient program as well?

Ms. HAGAN. We are outpatient, voluntary outpatient, and some mandated, yes.

Ms. THOMAS. Could I add to that?

Senator WILSON. Go ahead, Ms. Thomas.

Ms. THOMAS. Being outpatient, to me, is very helpful and it is very necessary, but I think it should be preparing a woman for residential treatment. Because in the end, the residential treatment is the only place that is going to get her out of the mix so she can get another perspective from out of it looking at it from the other side.

I do not think that she can drop in and keep dropping in and be successful as soon as—I mean, anything is possible, I am just saying that it should be in preparation of a residential treatment, I think.

Senator WILSON. Ms. Hagan, let me pursue this point with you. You made the point that those who are mandated to the treatment do less well, using your phrase, than those who volunteer. That makes sense to me. On the other hand, what I think is important is to ask, by "less well," do you mean that it takes longer, that their success rate is less?

Ms. HAGAN. Yes, I think they are resistant to treatment so it takes longer. They are very resentful about the fact that they have been mandated. They are not ready. I mean, I think Elaina would tell you that you really have to be ready.

But I look at things holistically. We look at things holistically, and one thing that I worry about with policy is that you are not looking at the entire problem. I mean, there is an entire cultural and sociological aspect of this that we know very little about. We have women who do not make prenatal appointments because their partners do not allow them to make prenatal appointments, to make the appointments on time.

There is a whole sociology that we need to examine when you begin to talk about making policy around this issue. For instance, let's say today we got rid of every drug, what are we going to do to support this population of individuals? That is a problem that we do not want to talk about, we are very uncomfortable about. Those are issues that we have to talk about. And I think with our women in treatment, we know that the important thing is to be able to give them some hope about being able to make enough money to survive, to support their children.

Senator WILSON. Yes, I think that we understand the importance of what you are calling a holistic approach, the kinds of things that Ms. Thomas has been doing by providing comprehensive ancillary support services that realistically will permit them to entertain hope.

The concern that I have is that there is a vast population that has not yet turned the corner, that has not made that decision, now I am ready, I am strong enough, I am prepared.

The women who need the help to get there—obviously, some are coming to you from county agencies—I assume that they are achieving at least some success even though they may resent it, they may resist it. After time, after they are helped, after they are withdrawn, don't they begin to have a different attitude? Isn't that the case?

Ms. HAGAN. I think that our women who do better in treatment, we offer something, we hook them up with other services in the system so that they have something to look forward to so they are not going back into the same neighborhoods, trying to get them housing out of the neighborhoods where they are so that they are not exposed to that. It is very, very helpful. Putting them in school is very helpful. I just had one young woman who was a crack addict. She came in the other day, she has gotten her graduate education degree, and she is enrolled in community college and they are offering daycare for her while she is going to college. This young woman has remained clean throughout her pregnancy because she was able to accomplish these things.

I think residential treatment is probably the better route to go, but those are the things that you offer in residential treatment.

Dr. TUCKSON. Senator, one of the things that is very important here, and especially as you talk to the Federal officials that will come later, each individual is in fact an individual. There is no standard blueprint for what type of program is best for everybody. One of the most important elements of a treatment system that makes sense is to individually assess then that person that is in front of you to see what their strengths and deficits are, what they bring to the treatment modality.

Those persons who are not highly motivated, sir, to be honest, are not going to have good outcomes. And there is no magic in this. There is no magical way that anybody in the treatment system is going to be able to have a good outcome for someone who simply is not ready to face the challenges that confront them.

On the other hand, we who have responsibility for spending money and for allocating money are going to have to be much better prepared with a database that says, these are the kinds of programs that give us the best chance for success in these kinds of cases and here is the best way, cost-effectively, to spend our money.

We have begun discussions with Dr. Schuster from the National Institute of Drug Abuse on this point and asking him the question, how do you evaluate a program like Mandella House in Oakland and the program here in Philadelphia and the one in Washington, D.C., that treats similar cohorts of individuals? How do you price those out, and how long should the program be? Should we be paying for a program that is one year long or 18 months long, both which have significant financial implications and quality outcome measures? How do you compare and contrast those elements that define success and those that do not and how much should you be willing to pay for those, given that we only have so much money to spend?

Those are questions, I think, that we really need a lot more national research on, and I am encouraged that the people at NIDA seem now to be looking at some of those issues.

Senator WILSON. Those are indeed precisely the questions we have got to answer. My own feeling is that the kind of success that Ms. Thomas has had, or at least that I think she is having—and I want to ask her a question about that in a minute—indicates there is need for treatment in a custodial setting.

I am sure you are familiar with the success that has been achieved by Dr. Mitch Rosenthal in the Phoenix House project. A great many of the people who come to him really do not come voluntarily. However, over time they make the adjustment and they are able not only to be withdrawn, but after that intensive round-the-clock family-like setting, oftentimes for a period of 18 months,—I know that it is similar to the tenure of those that stay at Mandella House—they have a fairly high success rate. By “fairly high,” I mean it is about 75 percent.

That is really at what I am getting. It seems to me that it is not terribly realistic to think that we are going to be able to bring everybody to the kind of treatment they need simply because they have the strength of a Dawn Horrell or have arrived at the time when they are ready to get clean. It seems to me that some are going to need some incentive.

I am thinking, Ms. Hagan, of the kind of approach that was taken in New York State in the 1970s when the Governor and the legislature devised a program for heroin addicts which involved a minimal time in a community based, mandatory rehabilitation.

Ms. Thomas, let me just ask you two questions. What does your program cost? I know it is funded by the county. What does it cost per person per day, for example?

Ms. THOMAS. The cost per person would be roughly \$100, \$96.40, I broke it out. We are operating at this point at \$45, but we are trying to get a supplementary budget. Because see, we started off like December 1987, and so I didn't have a track record. I have been working with ex-offender women the last 10 years, but this was my idea, so I guess I had to get a track record before I could get fully funded. But the success rate is, I would say, 75 to 80 percent that goes out and stays out there, because they come back to us.

Senator WILSON. About 75 to 85 percent of the graduates of Mandella House manage to stay clean?

Ms. THOMAS. That is right.

Senator WILSON. That was my other question. Thank you all very much.

Senator KOHL. Thank you, Senator Wilson, and thank you, ladies and gentlemen. You have done a great job and provided us with insight, information and sensitivity. We appreciate you coming. Thank you.

I would like to ask our second panel of experts to approach the table now. Our first witness is Dr. Ira Chasnoff, who is from Chicago. He is the Director of the National Association for Perinatal Addiction, Research and Education. And Dr. Chasnoff has done the ground breaking work on this issue. He is one of the few who is coming up with hard numbers on how many women and infants

are affected by drug and alcohol abuse. So we feel that we will be especially interested in hearing from him how his surveys compare with the one released by Secretary Sullivan this morning.

Our second witness is Gregg Coler. Mr. Coler comes to us from Tallahassee, Florida, via Chicago, where he was in charge of Children and Family Services for the State of Illinois.

Now Mr. Coler has taken his expertise to Florida where he is secretary of a huge umbrella agency overseeing health and human services. Mr. Coler is also Chairman of the American Public Welfare Association's Commission on Child Welfare and Family Preservation.

Finally, we have Dr. Howard Fuller. Mr. Fuller is director of the Milwaukee County Department of Health and Human Services, in my own home State of Wisconsin. He has had a very distinguished career, which I could spend all morning describing. Howard is an advocate of the very highest order. And we especially look forward to hearing about the Cocaine and Motherhood Project Howard has set up in Milwaukee to tackle the emergency posed by maternal substance abuse.

Our first witness—and I would like to ask you gentlemen to be complete but brief—is Dr. Chasnoff.

TESTIMONY OF IRA J. CHASNOFF, M.D., DIRECTOR, NATIONAL ASSOCIATION FOR PERINATAL ADDICTION, RESEARCH AND EDUCATION, EVANSTON, IL ¹

Dr. CHASNOFF. Thank you, Senator Kohl, Senator Wilson. The problems in substance abuse and pregnancy are not really a new problem. They were recognized in the United States on a full force by about the early 1970s. But most of the problems of drug use in pregnancy were associated with women who were receiving prescription drugs from their physicians. As illicit drug use has become more of a problem in the United States, we have seen an increasing number of women of childbearing age being involved with these illicit drugs.

A recent survey we did of 36 hospitals from around the country found that 11 percent of the women delivering in the 36 hospitals had used an illegal drug sometime during pregnancy. And in my written testimony you can see samples from hospitals from around the country.

Now, a point that has not been made strongly enough thus far is the involvement of the rural community. We are currently doing some work in rural America. Our organization was out providing a 2-day training program for health care professionals in Spokane last week and we are working with several groups from the Spokane area and a group from Wenatchee, Washington, which is a small community in Washington that has one community hospital. They have 25 to 30 deliveries per week in their hospital and three to four of those babies per week have positive urine toxicologies for cocaine. This is a report from the Division of Child and Family Services for the State of Washington. So that as we investigate further, we are finding that rural America is facing the same problems.

¹ See p. 70 for Dr. Chasnoff's prepared statement.

The other aspect of this that cannot be forgotten is that it is not just the poor, the indigent who are using drugs. We currently have a study that we will be giving the results of in September at our national meeting coming up, and we are doing the first survey, a county wide survey, of substance abuse in pregnancy by private health care women, women who are receiving health care from private obstetricians, comparing their rates to the public health care women in that same county. This is going to have a tremendous amount of implications for our health care procedures and policies of the future.

Now, I am not going to give more statistics per se, because we know what the problem is. We also know that infants exposed, especially to cocaine, during pregnancy have a high rate of prematurity, seizures, are at risk for congenital malformations and stroke.

However, we published an article just recently in the March issue of the *Journal of the American Medical Association* that tested the model that we have been working on for the last 13 years. This model provides comprehensive outpatient care to pregnant drug using women, and what we published in that article showed that women who are brought into the health care system, receive prenatal care and intervention, have a markedly significantly decreased rate of complications. You can, in fact, prevent the prematurity and the intrauterine growth retardation and the neonatal seizures if an infant's mother has received prenatal care and was drug free through their intervention.

Now, the financial implications of this are tremendous. In the State of Illinois in fiscal year 1989, there were 2,500 infants born to women who had used drugs during pregnancy and had a positive urine toxicology for cocaine at birth. Taking as a base only those 2,500 infants, which we know is only the tip of the pyramid, and figuring the prenatal health care costs of an average in our program of about \$5,000 for complete prenatal care, including medical as well as psychotherapeutic, these women would be hospitalized for 2 days at \$500 a day for their delivery care, and then the infants would be in an average of 2 days at \$500 a day, for a total cost per mother/child diad of about \$7,000.

However, cocaine using women with no treatment who received no prenatal care would thus have cost for prenatal care, but would be—the mothers, assuming they had no complications—would be in 2 days, but the infants whose mothers do not receive care are in the hospital for an average of 20 days at a cost of \$1,500 a day, for an average cost of \$31,000 compared to the \$7,000.

If we multiply that by the 2,500 infants affected in the State in just this very small sub-sample, the total cost difference is \$60 million per year, taking into account only the health care costs of the mother and child through one month after delivery—\$60 million.

Now, what are the implications for Federal policy? I think we have to base our policy on three basic concepts. Number 1, early identification of the pregnant substance abusing woman and referral into treatment will prevent the medical complications of the infant at delivery.

Number 2, the most commonly misdiagnosis in obstetric and pediatric medicine is drug use in pregnancy, thus the women are never referred to an intervention program. And number 3, even if

the diagnosis is made and a physician tries to refer the women, there are not enough treatment programs for pregnant women in this country.

So these are the three concepts upon which medical intervention, psychosocial intervention and Federal policy must be based. Now, about 2 weeks ago I had the opportunity to help the Office for Substance Abuse Prevention review grant applications from communities around the country to develop intervention programs for pregnant substance abusing women and postpartum women.

There were \$35 million in applications presented to OSAP. However, OSAP has \$4.5 million to provide funding for. So you can see the discrepancy. I think our intervention policies have to begin with identifying and providing access to health care for pregnant addicted women and high-risk women. We must train physicians to identify these women to get them into the health care system, and the public must be assured of nonpunitive, comprehensive care which will meet their needs.

We need not legislate health care and we need not resort to legal and punitive action if we look upon the pregnant woman as a special category of substance abuser rather than a special category of parent. Thank you.

Senator KOHL. Thank you, Dr. Chasnoff. Mr. Coler.

TESTIMONY OF GREGORY L. COLER, SECRETARY, FLORIDA DEPARTMENT OF HEALTH AND REHABILITATION, TALLAHASSEE, FL¹

Mr. COLER. Thank you, Mr. Chairman.

Substance abuse is just one factor making today's child welfare population significantly different from the children we saw 10 or even 5 years ago. The foster care population increasingly consists of older, more seriously troubled, and frequently severely abused children, young children with serious health problems, children of drug abusing or mildly retarded parents, and children who are mentally retarded or otherwise developmentally disabled, often as a result of substance abuse by their mothers during pregnancy.

Newborns and young children addicted to cocaine make up the fastest growing area of the child welfare population. Today in our largest cities one child in 10 is born addicted to cocaine. One out of three babies referred to child protective services in our cities is the child of a drug abusing parent. Crack babies are among our most challenging problems today. Not only are they born premature, and in many cases disabled, but they are also born lacking attentive, caring parents. They are two time victims of drug abuse.

This is the major issue facing the Nation and the public child welfare system, which is already overburdened and grossly underfunded. The incidence of newborn babies exposed to illegal substances and/or alcohol has skyrocketed in Florida. Each year the number of babies born afflicted with the AIDS virus doubles, and the number of crack babies grows exponentially. In 1987, the physical drug dependency of a newborn was defined as a type of abuse under Florida's child abuse statute, which changed our law so that babies born with a trace of cocaine in their blood immediately came under the jurisdiction of the abuse and neglect system.

¹ See p. 77 for Mr. Coler's prepared statement.

People who reasonably suspect that a newborn has been exposed to substance abuse are required under the statute to report this suspicion to the Florida Protective Services Abuse Registry. Upon notification of the Registry, they immediately contact a child protective investigator in the area. The protective investigator immediately conducts an investigation, which includes the immediate notification of the HRS County Public Health Unit. The County Public Health unit, through their nurses, performs a predischarge and postdischarge health care assessment of the home, the environment, and the parent or parents' ability to care for the health needs of the child.

In 1988, Florida had some 2,500 infants reported to HRS County Public Health Units for possible cocaine exposure. These cases were all reported to the Abuse Registry. Six hospitals in Florida have done studies on the urine of all newborns born during a certain limited time period without identifying the babies sampled. These studies tend to reveal that five times the number of babies reported actually had cocaine in their urine. Each quarter 27 to 33 percent of those babies weighed 5.8 pounds or less. Using an average figure of \$56,000 per hospitalization, those babies cost the State of Florida and the Federal Government some \$46 million. Estimates for the first quarter of 1989 reveal 897 cases, a 54 percent increase over last year, and in 60 percent of those cases the women received no prenatal care.

My colleagues and I feel that an adequate response to the problem of drug involved mothers and babies must address four major needs; one, a system of early identification of at-risk women; two, a system to increase prenatal care; three, a system of treatment and rehabilitation services for high-risk women; and four, a system of consistent policies and procedures concerning all aspects of working with the target population.

Thank you.

Senator KOHL. Thank you, Mr. Coler. Dr. Fuller.

TESTIMONY OF HOWARD FULLER, PH.D., DIRECTOR, MILWAUKEE COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES, MILWAUKEE, WI¹

Dr. FULLER. Mr. Chairman, thank you very much for this opportunity to testify on what I believe has rapidly become the most serious threat to this Nation's urban communities and to our children—drugs, and in particular, cocaine.

In the past 5½ years, abuse and neglect referrals have more than tripled in Milwaukee County, and we expect that total in 1989 to be 20 percent higher than last year's record number. Our child protection workers, the police, the District Attorney's office, and our Children's Court judges tell us that this startling increase in abuse and neglect of children can be attributed to one factor and one factor alone, drugs. In Milwaukee more often than not the drug is cocaine.

Let me give you a few examples of what drugs are doing to our families in Milwaukee, Wisconsin. Police went to a home where a neighbor had reported, "a child abuse in progress." What they found was a home infested with cockroaches and strewn with

¹ See p. 97 for Dr. Fuller's prepared statement.

broken glass, overturned furniture, rotten food, used syringes and razor blades.

A 25-year-old woman, the mother of three children including an infant, was passed out on a soiled bed. Her children had not eaten in 2 days, prompting her 7-year-old son to go for food to the neighbor who had called police. The children's grandmother said her daughter was a chronic cocaine user who sold their food stamps to buy drugs.

Secondly, a child protection worker responding to an anonymous tip went to a home she said she could smell from the street. Inside, living in filth, were eight children ranging in ages from 2 to 17, belonging to two sisters. Dirty dishes were on the floor. There was no running water and no food. The toilet and tub were caked with excrement. On the stove was a pot which had bubbled over and caught fire. Needles and blood-stained cotton balls were present and both women were on drugs, unable even to put out the fire.

Another case, acting at the request of a child protection worker, police raided a, "shooter house" where users purchased and took drugs. In the basement was a pile of hypodermic needles 1 foot high and 1½ feet in diameter. Living in the home were 14 people, three sisters and their 11 children, ranging in age from 1 to 17. Feces and garbage covered the floor, the tub and the toilet. The home had no furniture except a mattress with metal springs protruding. It had no heat, electricity or working plumbing. There was no food or eating utensils. There was only one adult there at the time, and she was on drugs, too incoherent to answer questions.

This is in the city of Milwaukee, this is not some rural area in Mississippi that we are talking about conditions like this that our kids are living in.

Until recently, our child protection staff received reports from time to time of infants born to drug abusing mothers with cocaine in their tiny bodies. However, Milwaukee County began to see a trend last fall when the number of reports from hospitals rose significantly. We began in January to keep track of these referrals. For a community the size of Milwaukee, the numbers are alarming. Through June, our Department of Social Services has received 134 reports of "cocaine babies" born in local hospitals.

These referrals are for situations where hospital staff fear the infant may be harmed if allowed to go home with the mother. However, the number of babies at risk because their mothers are addicted to cocaine is much larger than that. Hospitals in Milwaukee County estimate that, combined, cocaine is involved in 10 percent to 15 percent of all deliveries. Since they have from 12,000 to 15,000 deliveries a year, that translates to between 1,200 and 2,200 "cocaine babies" born in Milwaukee County each year.

This problem has become almost epidemic in our central city, where poverty caused by joblessness contributes to drug use. At one downtown hospital, 35 percent of the babies delivered during a one week period earlier this year tested positive for cocaine. Officials at this hospital say an average of 15 babies a month are born with cocaine in their systems. A second hospital serving inner city patients says it delivers an average of one "cocaine baby" a day.

Some inner city women apparently start using cocaine during pregnancy. In Milwaukee, the word on the street is that cocaine

will get rid of an unwanted pregnancy. Because cocaine can rupture the placenta and lead to miscarriages, this bit of street wisdom can unfortunately prove to be true.

Whatever their motivation, there apparently is no limit to the desperate lengths that these women will go to satisfy their craving once they are hooked. At one hospital a nurse walked in the room of an expectant woman awaiting delivery and found her snorting cocaine. At another hospital one newborn actually had a packet of cocaine on the top of its head as it came down the birth canal. The mother, in removing her clothing while awaiting delivery, had hidden the packet in her vagina.

The medical problems and potential disabilities of these infant victims of cocaine will be an incredible burden on our service system. They will require extensive medical care which, if they are even fortunate enough to get it, will most likely be publicly funded. They and their families will need supportive services at a time when we cannot even meet the needs of the frail elderly, the mentally ill, and the developmentally disabled persons who are now on our waiting list.

They will need special education programs when schools are already having difficulty achieving educational goals for children who are not impaired. Milwaukee County's health care and human service systems are at the breaking point. We must find a way to deal with this crisis.

Earlier this year Milwaukee County established a Cocaine and Motherhood task force to study the issue, inventory existing services to this population, and make recommendations on what Milwaukee County Government and the broader community could do to address the problem. The task force is made up of State, county and City of Milwaukee representatives. Numerous private social service advocacy and substance abuse agencies are also represented.

On a related track, a committee of health care providers and health maintenance organizations are looking at this problem, assisted by members of my staff, and will be working closely with the task force in developing recommendations. This collaborative effort, we have found, is a significant breakthrough in trying to deal with this problem. A major obstacle to effectively serving this population is that the cocaine abusing mothers and pregnant women now interact with three separate service systems, all of which deal only with a segment of the problem and none of which are accustomed to collaborating with each other.

The health care system deals primarily with the prenatal and post-delivery medical needs of the mother and infant. Drug treatment professionals are involved solely with the addiction, often with little thought as to how a mother in treatment can continue to care for her children. And child protection workers are charged with monitoring the physical safety of the child. As a result, many times child protection staff, drug counselors and therapists, and physicians and public health nurses often work in isolation, not as a team.

What can the Federal Government do to assist Milwaukee County and other communities in combating this problem? I would suggest two things. First of all, funding is desperately needed to

support the full array of services which are needed for this population, including residential treatment programs where children can stay with their mothers.

Second, more coordination is needed at the Federal level. Recently our department has received notice of seven Federal grant opportunities, some targeted at different substance abuser groups, including intravenous drug users, youth gangs, homeless or runaway children, youth which are considered, quote, "to be at high risk," and pregnant and post-birth mothers.

Some grants are for treatment or prevention, others for prevention only. Each grant by itself addresses an important dimension of the drug problem. Unfortunately, the seven grants are being disbursed by six separate Federal agencies. We believe that the coordination that people ask for us to do at the local level is needed at the Federal level.

In disbursing Federal funds, it is important to give local jurisdictions flexibility to address local needs. I have no quarrel with accountability, but it is a question of who can best determine what specific programs are needed to meet the problems that we are facing. I believe the community should make the decision as to where whatever limited resources are available can best be used.

It is clear that drug abuse has become one of our country's top domestic priorities, and while it is nice to hear from Mr. Bennett and the Secretary that drug use has gone down, someone should pass that information on to the central City of Milwaukee, because we are not aware of it. What we see is a continuing epidemic, and an epidemic that is beginning to affect not only the mothers but the children and, by definition, the rest of us.

The emphasis that we have heard on law enforcement is understandable and very important, but we cannot ignore treatment, which has to be directed at the drug abusers if we are to help their children. I urge you to consider not just the present reality, but the future of our country as you grapple with what to many must seem to be an intractable problem.

We must ask the question, what will our Nation be like when these physically, emotionally and developmentally damaged children become adults. We already have a generation of young people roaming our streets who will kill you just as soon as to look at you. We have kids listening to "NWA" and "Ice Tea" and "Easy E" while we are sitting around talking about the relative merits of dealing with this problem.

I do not want to face these kids on the street when they get to be 15 and 16, because you are going to be looking at children who have no concept of the value of life, because it is meaningless given the conditions that they are facing. And if we don't do something about this problem now, the problems that we think we have in 1989 are going to pale to the problems that we are going to have in the 21st century when these children become adults.

Thank you very much.

Senator KOHL. Thank you, Dr. Fuller.

I would like to recognize the presence of Senator Carl Levin here this morning. Senator Levin, do you have a statement to make before we proceed?

Senator LEVIN. No. I just want to thank you, Mr. Chairman, for what you are doing here this morning, and thank these witnesses for their very moving and total commitment to eradicating, or at least reducing, the devastating effect of drugs on our society. We are grateful to you.

Senator KOHL. I am going to raise the same question with all three of you, and it relates to what you have been saying, what Dr. Fuller put very precisely. You are here today to talk to the Federal Government and we are interested in your recommendations. We are interested in what you think needs to be done, how it should be done, and what we can do to help you get the job done. Let's hear about it.

Dr. Chasnoff, tell us straight. Tell us what we need to hear.

Dr. CHASNOFF. I think there are three major areas that we need to focus on. The first is education on two fronts, both public education—

Senator KOHL. Pardon me, in terms of what the Federal Government—

Dr. CHASNOFF. Right, and the Federal Government would also start backing professional education for physicians. And, taking that a step further, going on a State-by-State basis, the Federal Government would begin developing programs that would coordinate Federal monies at the State level to bring in departments of children family services, departments of alcoholism and substance abuse to make sure that there is not repetitive use of the Federal funds, but all these agencies. We have developed a model such as that known as the Illinois Model.

And then, finally, we have to address issues of access to health care. I think we have to move away from the legal and punitive areas and begin developing methodologies for making programs accessible. At a Federal level, the Office of Substance Abuse Prevention has tried to begin implementing these issues, but what I must caution is as we develop community-based demonstration programs, we must keep science involved.

We cannot go out and spend Federal money on programs that look good without appropriate evaluation, and the agencies such as OSAP and National Institute on Drug Abuse must see that any programs they are sponsoring are founded in science and have a complete evaluation process, because if we don't evaluate programs appropriately, we are going to find that we have funded a lot of programs that really don't work but sound good. They may save a few people, but in a comprehensive manner, they are not going to make any dent in the real problem.

So I see the Federal Government taking the leadership in organizing and coordinating services by the state, and also in developing and evaluating interagency comprehensive programs for pregnant women and their infants.

Senator KOHL. Okay. Mr. Coler?

Mr. COLER. Well, one very specific recommendation that I would make currently is pending before Federal rulemaking, a decision on whether or not to include drug treatment as a part of the reimbursement to the states under the Family Support Act. A significant part of the welfare population is drug dependent. The key

focus of that bill are teenagers who are on welfare and have children.

If we are going to have some chance of being able to help them towards independence, certainly for many of them the first step is going to be to be able to deal with their addiction. And that bill could be a primary place where we could identify for early treatment individuals who need it and could be a primary source of funding for it. So I would certainly urge that drug treatment programs be included as part of those services under the Family Support Act.

In order for a State or a locality to adequately address this system, they are going to have to effectively coordinate the public health system, the child welfare system, and the drug and alcohol abuse system, whatever that might be. All of these bureaucracies and enterprises of the Federal Government have dozens of jurisdictions, committees, and staff, and there really isn't a very coherent approach and recognition of the tremendous amount of coordination that is necessary when these babies are identified.

For instance, when the baby is born, or before, if that mother is identified, then we in Florida send both our public health nurses as well as our abuse and neglect investigators to immediately look at the child. Their children are already covered by the Abuse and Neglect Act. They are not in every State.

So I would also recommend that the 1974 model Abuse and Neglect Act immediately be looked at again, that new recommendations be given to the States that will allow them to consider the range of options in terms of how can you immediately include these neonates under the abuse and neglect system, not waiting for some of the horrible abuse that Dr. Fuller described to occur before you can go out and intervene.

So the question of how we are going to protect these kids that have got a neon sign across their chest that they are in great danger of being abused I think is a critical policy issue that the Federal Government should work with the states on in terms of providing the best blanket of protection that we probably can.

Senator KOHL. Dr. Fuller?

Dr. FULLER. Well, Senator Kohl, as you know, I am not very optimistic about this war on drugs that people have declared. I don't think we are winning, I think we are losing. I think ultimately the Federal Government is going to have to make a decision, are we going to rebuild communities or try to build jails, and I don't think you can do both of them. And I think the reality of it is that you cannot help these families and the kids if you cannot do something about the communities in which they live. It does not do any good to put people in a residential center, an outpatient treatment center, let them out, nothing changes about the community that they left from.

We cannot deal with the underlying causes of poverty if we cannot deal with the fact that in central cities, like Milwaukee people do not have jobs, they are living next door to boarded up houses. Everything about where they live is negative. And unless we can begin to rebuild those communities as a part of rebuilding the lives of the families that we are talking about, I don't think any of this stuff is going to make any difference, frankly.

And so to me what I see we have to do is we need resources to attack the environment in which people live, and we have got to change the conditions of poverty, even as we continue to talk about treating people, or else it is going to be very difficult for people not to get back on the drugs, not to go back into these negative behaviors.

And I don't think, in a county like Milwaukee, where I am going in asking for 117 positions in protective services, I am asking for \$30 million more on the tax levy right now in the 1990 budget just to begin to try get case loads down to a point that you can actually say you are serving this population, whether you are serving them through intake or whether you are serving the foster care homes.

And then we are going to talk about what is it that we do to reconstruct communities. That is going to take funding, and I know I just don't think that local property taxes are going to be enough to deal with the gravity of this problem.

And if the Federal Government does not intervene, I frankly don't know how we are going to be able to carry out this task.

Senator KOHL. I thank the gentleman. Senator Wilson?

Senator WILSON. Thank you, Mr. Chairman.

Dr. Chasnoff, you expressed one rather optimistic note fundamental to your idea of what can be done. And that is that if there is early identification of the substance using pregnant woman, then there will be time through treatment, to get her off drugs and avoid the otherwise, in some cases, irreversible harm to the child.

How early do you have to identify the woman and get her into treatment in order to be able to avoid those consequences?

Dr. CHASNOFF. Well, if we divide the pregnancy into trimesters, there are particular advantages to each trimester. If you identify the woman in the first trimester of pregnancy, the first 3 months, and get her off drugs, then you prevent much of what we were talking about, including many of the malformations.

Our concept of malformations is changing. There are many people who used to say that malformations occur only by exposures in the first trimester. Cocaine is different, because what we have found is that cocaine acts on the cardiovascular system and cuts off the blood supply when a person uses cocaine. It causes blood vessels to constrict down.

What we have found is a baby born even to a mother who used only in the third trimester, had no cocaine use during the first two trimesters, that infant is at risk. Some examples would be a baby whose bowel has formed normally, but the mother uses cocaine in that last part of pregnancy. The blood vessels to the bowel can constrict down and we see something called ileal atresia when the baby's bowel infarcts and he is born missing part of his small intestine.

Another example is a baby whose mother uses no drugs during pregnancy until the very end and uses cocaine toward the end, many times to begin labor and delivery, and the baby will have a stroke in utero, much as adults have been shown to have strokes and heart attacks from cocaine. So first trimester intervention will prevent many of those malformations and it will also prevent the prematurity and the intrauterine growth retardation.

Second trimester intervention will help prevent the malformations, but they are still at risk for miscarriage and premature delivery. Third trimester intervention will at least prevent, to some extent, the intrauterine growth retardation, because the majority of growth for the fetus occurs in that third trimester.

Our studies have shown this with cocaine. There are other studies that have also shown the success of intervention with alcohol in that a group in Boston published reports that women who are overtly alcoholic, if they receive intervention by the beginning of the third trimester and stop using alcohol, you can significantly decrease the rate of fetal alcohol syndrome.

So that, again, there is a methodology, but there are some glitches in the methodology. The first is getting women into treatment, either by self-referral or by physician referral. And that is not what is happening in this country. The medical system has failed this population.

There are women who are being identified as to their drug use simply because of their membership in a racial class. I have talked with numerous hospitals around this country who have been developing screening programs and they have told me, yes, every high-risk woman who comes into our hospital gets a urine toxicology. Then taking it further, I asked, well what do you mean by "high risk"?

And what we finally come down to is that in many hospitals in this country, any black woman that enters the hospital is having a urine toxicology performed; on the west coast, any Native American woman or any Hispanic woman. This is doing an injustice, of course, to these minority population women. It is also doing an injustice to the white middle class woman whose physicians are afraid to ask about her drug use and who usually approach the problem of drug abuse by asking a simple question of the pregnant woman, "You don't do drugs do you?"

Senator WILSON. It seems to me that the injustice is not to a particular group of women but to their children. Isn't that what we ought to be concerned about?

Dr. CHASNOFF. Absolutely.

Senator WILSON. Perhaps the answer is urine toxicology as a universal health requirement.

Dr. CHASNOFF. Well, I think that urine toxicologies on pregnant women are simply a short cut. They are a lazy way of approaching the problem. Our studies have shown—and Mr. Coler also addressed this issue—that when you do urine toxicologies only, you only find about 1 out of 5 infants exposed, and in our studies it is about 1 out of 3 to 1 out of 4, so we are all in the same range.

However, if every pregnant woman, as part of her assessment, if physicians became comfortable with substance abuse and every woman had a substance abuse history, you can much more efficiently begin finding women who are using drugs during pregnancy. Urine toxicologies on every pregnant woman are not the answer.

Senator WILSON. Let me come back to that, but before we do, I want to pursue what I began asking you.

Dr. CHASNOFF. I am sorry.

Senator WILSON. I would think that the more common situation would not be the mother who uses right up to the time of delivery, though I do know that some use drugs in order to speed the labor and, presumably, make it easier. Whether that is medically true or not, it is street wisdom in a number of places.

I would think the more common situation would be the young woman who is using who learns that she is pregnant who wishes to stop using during pregnancy in order to spare the child. Let's just take the case of the mother who is using crack and discovers she is pregnant and stops after a month, after two months, after the first trimester. What would be the impact on the child?

Dr. CHASNOFF. A woman who is using in the early part of pregnancy will have a very high risk for spontaneous abortion. And, in fact, cocaine is being used to induce abortions by many women, so that many women will not know that they are pregnant and they have already induced an abortion by using the cocaine. That is in the first or second month of pregnancy.

By the third month of pregnancy, women are beginning to recognize their pregnancy, and that is a key time to bring them into treatment. Now, our studies have also shown that if we find these women in the first trimester, get them into health care, we can prevent or decrease the rate of medical complications.

However, the neurological complications and neuro-behavioral changes that we described in these infants—the irritability, the high pitched crying, the tremulousness, the difficulty in interacting—babies exposed only in the first trimester of pregnancy and have been drug free and have had no drug exposure during the last two trimesters will still manifest all of these problems, because the system in the brain that controls neuro-behavior and neurological development, develops in that early first trimester, many times before the women know they are pregnant.

So that even if we can find these women and get them into treatment as early as the second month of pregnancy, a good number will still have babies who are irritable and difficult to care for, and that is why these intervention programs are also necessary, because part of it is teaching the women parenting skills and how to take care of the special needs of these children.

Senator WILSON. Let me go to a point you made in your testimony. You said early identification of the pregnant substance abusing woman and the provision of treatment services to teach her to abstain from drugs will prevent the obstetric and neonatal complications of perinatal addiction. That is what I really think we need to be focusing on.

I am delighted that Mr. Coler is here with you, as well as Dr. Fuller, to explain the Florida experience. You have indicated the need for early detection, and part of that is the adequate training of physicians.

Let's assume though that you have the situation where the physician has been trained but is operating in a state other than in Florida where the law requires reporting. Let's also suppose that he says to the pregnant mother, you are using. You are threatening great harm to your child. I want you to submit to treatment. I want you to get clean. If she chooses not to take this course of action, what are the doctor's options?

Dr. CHASNOFF. I think—okay, let's address that issue first. If a woman is actively using drugs and refusing medical care at this point, there is no intervention in the State of Illinois that will mandate her coming into treatment. There are some agencies that on an individual basis will physically take that woman into treatment and bring her into our program, or other programs in the city. But there is no provision for those women who do not want access to health care. If they don't want it, there is no way that we are making them.

Now, the better option is to provide a system where these women can bring themselves in. And the way that we did this in the State of Illinois is we developed 2 years ago the Cocaine Baby Help Line, and it is a professionally run help line that is open to anyone who calls. We started and after 3 months we became so overwhelmed with calls that we got extra funding from the March of Dimes to expand it through the seven midwestern States. In 2 years we have had 2,700 telephone calls.

The average gestation age at which women were calling initially was 28 weeks gestation and, as it has become better known, our average gestation age at which they are coming into to self-referred treatment through this Cocaine Baby Help Line has now gone down to 12 weeks gestation.

So if you make it accessible it will, and you do not have to mandate this if you provide programs that will give women the chance to come into a nonpunitive atmosphere and who will come in and bring whatever resources they have into the system.

I have looked at programs across the country that have paid women to come into prenatal care and my feeling about this is that if you pay the drug addicted woman to come into prenatal care, you are giving her a source for more money. And so we do not do this and, in fact, the only thing that we offer to women to come into our program is good, comprehensive medical and psychotherapeutic care. And it works.

Now, the problem is we turn away as many women as we can accept because of the limits of our budget. We treat 100 women per year and their infants. And we have a total in our long term cohort of over 400 babies. Our follow-up one year after delivery is that 79 percent of the women are still in treatment with us and our oldest children are now 9 years of age. So that we have a system of clinical treatment that at the same time is providing us research information as to what works and what does not.

Senator WILSON. Dr. Chasnoff, does Illinois have a law similar to Florida's?

Dr. CHASNOFF. We have a mandated reporting law at birth. If a baby is born with illicit drugs in his urine, it is a mandated report.

Now, those are the 2,500 babies I was talking about before that had no exposures to prenatal health care. That is a mandated report. That came out of the fact that we did some studies in Illinois, and actually Mr. Coler was the director of the Department of Children and Family Services when most of this was put together, and he can talk about some of that.

But we have found that infants born to women who have used drugs during pregnancy, if they have not received treatment, are at extremely high risk for abuse and neglect. And so that these in-

phants are a mandated report in the State of Illinois, but after delivery, not during pregnancy.

Senator WILSON. Would you then agree—and I can ask this of all three members of the panel—that the best solution is one in which a State offers a combination of an aggressive outreach program that advertises the accessibility of care to the pregnant mother to attempt to induce her to come in voluntarily and in the event that outreach fails, a statute that requires a mother to submit to treatment if her child is born addicted?

Dr. CHASNOFF. Yes, I think after delivery, if a baby is born with a positive urine toxicology, that is a very reasonable approach. The difficulty is trying to extend this back into the prenatal period. We have found that when you try to extend mandated reporting back into the prenatal period, all you do is drive women out of the prenatal health care system. We had a significant example of this recently. An attorney in northern Illinois charged a woman who delivered an infant who had cocaine in his system—the baby died after 3 days—charged her with manslaughter and with delivery of an illicit substance to a minor.

On our Cocaine Baby Help Line, as that hit the media we had literally hundreds of calls from women who said, I followed your advice, I talked to my obstetrician, told him I was using, but now are you going to take my baby away from me? Am I going to be charged? And if so, then I am going to change obstetricians and I am not going to tell him about my drug use.

So that the best system is one which provides comprehensive access prenatally and mandated reporting at birth.

Senator WILSON. That makes sense to me.

Dr. FULLER. I would just add one other thing though. I mean, I think it is reasonable if in fact there is going to be treatment. One of the things that happens is people come down with all these mandates, but what does not come down with it is any resources. So that it is an illusion that we give people, and then we are surprised and make speeches when these programs don't work, because they are never really funded in a way where they can work.

Dr. CHASNOFF. That is one of the key issues in the new OSAP proposal that was written into the drug omnibus bill, that it concerns not only pregnant women but postpartum women. And I know, in reviewing the OSAP grants, there are several applications looking at developing comprehensive programs for the postpartum women and to test those kinds of systems.

Senator WILSON. How many States have prenatal outreach and mandatory reporting after birth?

Dr. CHASNOFF. Well, not many States do have the systems intact. As a matter of fact, I was meeting with the Governor of Ohio yesterday before coming out here in developing a program for the State of Ohio. It is what we call the Illinois Model, most of it as I have described it here today. And it is a system to coordinate health care through the Cocaine Baby Help Line and physician education and then comprehensive services prenatally and postpartum. And on a State-by-State basis that is what our association does, is help set up these systems.

Unfortunately, we get calls from States that don't have the funding even to get these kinds of programs started. It is interesting, in

reading the Washington Post story, this child is from Prince George's County, and on November 6th and 7th we will be coming out to do a 2 day session in helping them develop some comprehensive services for their county in addressing the issues of pregnant women and their children.

Senator WILSON. Chairman Kohl asked what the Federal Government could do to help solve the problem of maternal substance abuse. Would it be useful in light of the circumstances that you have described for the Federal Government to attempt to encourage states to enact a plan for both prenatal outreach and postpartum care and mandatory rehabilitation by offering resources through a grant program to states?

Dr. CHASNOFF. Yes, I think that the way that the Federal Government can provide this kind of leadership is by putting funds especially for pregnant women into each state requiring—I think it needs to require that services be coordinated amongst the different agencies. Many times, and we just had the experience in Washington State, there were people sitting in the audiences from the Department of Child Protection, the Department of Alcoholism, the Department of Substance Abuse, who had never met each other before but had clients in common. And one system was taking care of the drug addiction, the other system was doing the child protection work. And so the key is developing monies to put aside for states to develop these comprehensive coordinated programs, and you are going to develop a much more cost efficient modality.

Senator WILSON. That is precisely one of the requirements of the legislation that I am introducing today. And I might add we are urging that \$50 million be made available for demonstration grants to states that have done what Florida and Illinois has.

Mr. COLER. I might add though that on any given day, given our best efforts to have an integrated system, we have got 2,000 people who need drug treatment. We don't have it for them. We have made the policy decision to move women who are pregnant with addiction to the front of the drug treatment line. No matter how long it is, they are going to go to the front because we have got the baby in utero or the neonate to be concerned about.

Senator WILSON. I congratulate you on that decision, because I think you are practicing probably both medical and fiscal triage.

Mr. COLER. But even with that, I would not guarantee you it is working perfectly. There is resistance to that kind of triage. But I really think one of the most difficult jobs is the one you are going to have here at the Federal level. We are fortunate in Florida to have an umbrella agency, where under one jurisdiction we have what in Illinois is eight separate departments. In Wisconsin you have a county administered system, which makes it tough, too, because the state and the counties are independent of one another in terms of who runs the programs.

But here at the Federal level, the amount of communication that has not gone on between the Assistant Secretary for Health, the Assistant Secretary of the Office of Human Development Services, the Assistant Secretary for the support administration, the WIC program within Agriculture, there is not—that is not a common thing that occurs.

All of those various jurisdictions—and there are many others than the ones I named—put out grant monies, put out policy directions, try to move the states and localities in ways that we think will be beneficial for their clients. But there really needs to be some cohesion to the notion of what is the Federal Government, how are you providing leadership, information, technical assistance to the states to help them do this.

I can assure you, there is a great hunger for that. Recently in Tallahassee in the hot month of July we had people from over 30 States come together to talk about abuse and neglect. Dr. Chasnoff came down and put a session on with a whole half day just devoted to cocaine babies. Everyone paid their own way and what-not and there was just a tremendous willingness among the States to share information: what are you doing, how can we get an answer to some of these problems.

And I really think that is a good role for the Federal Government to be providing that expertise, to be knowing what the different states are doing, and to provide the assistance and to target the various discretionary monies that are available in the different departments and jurisdictions so that there is a cohesive policy and programmatic model that we are working towards that we think makes sense.

One thing I can guarantee you, if you don't have the Health Department and whoever is responsible for child abuse and neglect, and the people who are running drug treatment in some kind of a state of coordination, you are going to have a lot of kids who are going to suffer terribly, a lot of people will not get help, and a whole lot of resources are going to be running off in different directions when they need to be very focused and concentrated on these women who are greatly at risk and their babies, who are likewise.

Senator WILSON. Mr. Chairman, in response to that, I would point out that under the grant program that would be authorized under my bill, the applicant state would have to submit a plan. One element of that plan would be a description of the manner in which appropriate services will be coordinated, including prenatal and post-natal medical care services, drug abuse education and treatment services, crisis counseling services, support group services, parent training services, and child developmental services.

I think we are thinking along the same line.

Dr. FULLER. I would say one other thing, Senator Wilson, one thing we have to remember is yes, it is important to put those people in the front of the line, but the people who are in that line are going to be some of the same people who are going to have an influence on that person that you put in front of the line getting back on drugs.

I mean, we have got to keep thinking about this line and who is in that line. And so while I think that a lot has to be done in terms of prevention, we have got a tremendous problem out here in terms of people who need treatment. And it is not just, you know—for example, one of the things that people thought in Milwaukee was that the women who are coming in who are birthing cocaine babies are first-time mothers. The statistics show that that is not true, that in fact it is older women, at least in Milwaukee, and they have

had 2 or 3 children. It is not the teenage mother who everybody sees in their mind.

And so what we are seeing here is the total impact that that has then on a family that already has 2, 3 or 4 children. I just think that we have got to keep those things in mind.

Senator WILSON. Thank you, Mr. Chairman.

Senator KOHL. Mr. Coler, did you want to make another comment? Did you want to say something else?

Mr. COLER. I just wanted to make one other comment in terms of the pressure that this problem is going to put on the system. And that is the recruitment of foster parents to take care of these children who come into our system. Dr. Chasnoff referred to the shrill cry that these babies have. Anyone who has walked through a neonatal intensive care ward and heard these cocaine babies crying, to think of who is going to have it within their heart to listen to these babies cry 24 hours a day as they go through the pain—we have a hard enough time recruiting foster parents as it is, with all the women who have gone back to work and the two working families, it is extremely difficult just to keep ahead of the curve.

We have got a whole unit of people at Jackson Memorial Hospital who do nothing except work with the hospital staff so that as those babies stack up we can get them moved out of there as quickly and possible into the foster care home. But I can't tell you how difficult it is to find the foster parents and, again, the adoptive parents, we are going to need for many of these children who are going to end up and should end up under the custody of the State, because if they don't, their fate is going to be a pretty harsh one.

Dr. FULLER. We are actually facing the return of orphanages. People don't want to talk about it, but the fact of the matter is that the problem is in long term care, and you cannot keep shuffling these kids around from foster home to foster home.

As was stated, they are very difficult to take care of. You cannot hold them, you cannot—you know, just loving them is not enough. And it is just an overwhelming task for many of our foster families.

Senator KOHL. What comes out in these comments again and again is that we have a national emergency, that every time we produce another damaged baby we have all these problems that we are talking about. And it saddens me to think about the bureaucratic process that takes place here and will have to take place here in Washington—perhaps not, but probably so—until we get some recognition and some action on it.

If the powers that be wanted today to declare a national emergency and to appropriate the money and the coordination of services, they could. And if that would result in 1,000 or 2,000, or 3,000 fewer of these babies being born a year, that would be money well spent, as well as humanitarian. And I cannot help but comment again, as I did in my opening statement, that back in the 1950s when we had a polio epidemic and we talked about 200 or 300 or 400 fatalities a year, we were the kind of a country that declared a national emergency. And today our values, for whatever reason, are such that we don't.

Well, thank you for coming gentlemen, you have been very helpful.

Senator WILSON. Thank you very much, gentlemen.

Senator KOHL. We will take a 2 minute break and then we will have our third panel.

[Brief recess]

Senator KOHL. We will move on with the third panel now.

The witnesses on this panel are Federal experts, and I would like to give them all a special commendation. At most hearings in the Senate, Federal witnesses testify first. And I want everybody to know that our agency witnesses today volunteered to testify last so that they would have the benefit of hearing the problems, frustrations and representations of the first two panels of parents, professionals and providers.

We have very dedicated public servants with us here this morning and we are all very fortunate that you are willing to be here. We look forward to hearing all of your ideas on how we can establish a continuous, coordinated comprehensive approach to the crisis posed by maternal drug and alcohol abuse.

Mary Sheila Gall is Assistant Secretary for the Office of Human Development Services within the Department of Health and Human Services. In addition to having a distinguished career in Government, overseeing children and family policy and programs, Ms. Gall is the single adoptive parent of two children.

Dr. Elaine Johnson has also had a very distinguished career within the Department of Health and Human Services. As Director of the Office for Substance Abuse Prevention, Dr. Johnson is on the front lines of coordinating and delivering prevention services to communities around the country. We look forward to hearing more about the comprehensive pregnancy demonstrations to whom you will be awarding \$4.5 million in grants.

Mr. Scott Dunn, in his capacity as Acting Administrator of the Food and Nutrition Service at the Department of Agriculture, has already been working closely with Elaine Johnson to coordinate the WIC program with drug abuse prevention and treatment efforts.

We are very pleased to have the Defense Department represented here today by Mr. Peter Brock, who is the Director of Alcoholism and Mental Health Programs at the Defense Department. So often we fail to look at model programs for military families, and yet the Pentagon is often far ahead of the rest of us as far as child care programs are concerned. And so we look forward to hearing from you, Mr. Brock, and about the problems you are seeing and the remedies that you trying.

Finally, James Forsberg is with us this morning. We are very pleased to have the Department of Housing and Urban Development represented here. Mr. Forsberg is Coordinator of the Special Needs Assistance (Homeless) Program within Community Planning and Development.

Given that some of the witnesses on the first panel mentioned how much of a problem housing was for pregnant addicted women trying to get off drugs, we will be very interested in hearing from Mr. Forsberg.

Before we start with your testimony, I would like to thank you for being here today. We are really just trying to come up with ideas for taking steps to meet the crisis posed by maternal substance abuse. We understand that no one has the perfect model for coordinating efforts, but your being here and listening and participating in our dialogue will greatly help us to come up with some answers to our problems.

Thank you very much, and we will start with you, Ms. Gall.

**TESTIMONY OF MARY SHEILA GALL, ASSISTANT SECRETARY
FOR THE OFFICE OF HUMAN DEVELOPMENT SERVICES, DE-
PARTMENT OF HEALTH AND HUMAN SERVICES ¹**

Ms. GALL. Thank you Senator. I have a formal statement for the record, but I would like to briefly comment on a number of issues. Dr. Howard Fuller presented a very graphic description of the problems families face as a result of drugs. It is a pretty sad situation today when we have throwaway bottles and cans, and we have throwaway diapers, and today we have throwaway children.

If you look at the populations we serve in the Office of Human Development Services, we serve children in foster care and their families, we serve families at risk by providing preventive services. We serve children and their families in the Head Start, the Developmental Disabilities, and the Native Americans programs. In every program we see drug abuse as a compelling problem.

As you know, Head Start is a comprehensive program that provides education, nutrition, and social services to help pre-school children and families in need. Head Start serves over 400,000 families and over 20 percent of those families report that their major problem is related to substance abuse. That gives you a telling comment about the seriousness of drug abuse.

Perhaps of even greater concern is the number of children coming into foster care as a result of drug abuse; the number of children who become victims of child abuse as a result of drug abuse; and the number of children who don't come into foster care, but who probably should come into foster care to escape from drug abuse. We had a number of children during this past year in the District of Columbia who died as a result of their families' drug abuse. They were murdered by their families, by their parents. Some of these were children whom caseworkers had presented to the courts requesting that they be brought into foster care.

We have devoted a lot of attention today to pregnancy and the crack baby situation. Certainly this presents very difficult and new challenges for our foster care system and for our child protection services people.

Our social workers and others come into contact with pregnant women with drug use, with crack babies with drug use and with the other children who are left at home. And sometimes we forget that these pregnant women who are drug addicted often have a number of other children in the home. The social workers are meeting new legal and medical concerns that they have never dealt with before.

¹ See p. 102 for Ms. Gall's prepared statement.

For pregnant needle drug users there is a high risk, as you know, Senator, of HIV infection for their babies, and that presents another new challenge for us. For our caseworkers, the issues are enormous. For our foster parents, the issues are enormous. If you consider our HIV infected children or our AIDS children, there are a number of very difficult issues that foster parents and caseworkers have to deal with. One very simple example is confidentiality concerns. We have heard time and time again that foster parents are not allowed to form support groups when they are caring for AIDS children because that would violate the confidentiality of the child.

Foster parents who care for AIDS children are not allowed to tell grandma who comes in to provide respite care that that child has AIDS. This does not help the child and it does not help the person providing that care.

So there are a whole host of issues. Certainly there are others at this table and who have made presentations this morning who are much better versed and experts in treatment and prevention, but I can tell you that the impact of drug abuse on our families is dramatic and it is frightening. It is something we have to deal with through our caseworkers, and with training and respite care for our foster parents. But we are grasping, sir, for help and we are trying very hard to coordinate with the other people at this table and others in the Federal Government.

These are some of the things that I have seen in meeting with judges, caseworkers, and others who provide services at the local level. As I travel around the country I have asked them to all sit down and talk about these problems and drug abuse always comes up as the first agenda item. And very often, Senator, this is the first time that they have actually sat down and talked to each other. So, certainly, coordination is a very important component of services delivered at the local level.

When I was out in Kansas City recently I talked to a number of caseworkers. Their concerns were not only the crack babies being born in their hospitals every month, but also the runaway children, the teenagers who are in the street and at risk of tremendous drug abuse, teen pregnancy, and AIDS babies. In short, there are a lot of new issues that they have to deal with, and we are all going to work very hard together to try and resolve these issues.

There have been coordinated efforts at the Federal level before, but certainly this is something we need to do more of and I am here today to help in any way I can.

Senator KOHL. Thank you, Ms. Gall. Dr. Johnson.

TESTIMONY OF ELAINE M. JOHNSON, PH.D., DIRECTOR OF THE OFFICE FOR SUBSTANCE ABUSE PREVENTION, DEPARTMENT OF HEALTH AND HUMAN SERVICES ¹

Dr. JOHNSON. Thank you, Senator Kohl, for inviting me to participate in this hearing today to examine the coordination of Federal policy for prevention, intervention, and treatment services for women, infants and children.

¹ See p. 116 for Dr. Johnson's prepared statement.

As previous witnesses have testified, we have a very serious problem of drug use during pregnancy in our country. Increasing numbers of women are using illicit drugs during their pregnancies, thereby producing a catastrophe for our most innocent citizens, babies born to substance abusing mothers. The survey that was released today, by the Department of Health and Human Services, the National Household Survey, found that more than 5 million women of child bearing age had used an illicit drug in the past month.

You have also heard from Dr. Chasnoff that, based upon a study jointly supported by the Office for Substance Abuse Prevention and the March of Dimes, in 36 hospitals around the country, an average of 11 percent of pregnant women use drugs.

We believe that these are conservative estimates in that some hospitals have reported higher percentages, and Dr. Chasnoff found variable screening practices among the various hospitals he had studied.

However, this estimate means that today, July 31, 1989, over 1,200 babies will be born to women who have exposed their infants to drugs during pregnancy. These figures do not take into account the widespread use of alcohol by pregnant women, which would dramatically increase the number of infants affected. Each year that this problem goes unchecked, the number of these innocent victims compounds, with new damaged babies adding to those already born and suffering.

One of the most striking public health policy problems is the complete inadequacy of our current approaches to service delivery. At OSAP we believe that this is a multifaceted problem requiring well coordinated multiple systems of involvement. This problem requires the development of new and innovative outreach services for these women, as well as access to appropriate prevention, education and treatment services.

Let me describe very briefly some of OSAP's efforts to respond to this problem. In its very short history we have worked to develop a variety of collaborative efforts at both the local and Federal levels. First at the local level, the challenge has been to design programs that can be preventive in focus and comprehensive in design, involving prenatal care drug treatment and infant/parent support. OSAP has sponsored and evaluated perinatal programs to develop linkages in service delivery and supports coordination models through its High-Risk Youth Demonstration Grant Program.

I would like, for the sake of time, to cite just one example, Operation PAR, Inc. in Florida. This is a substance abuse prevention and treatment program. It combines aggressive case management and outreach to pregnant substance abusing women with a variety of treatment and rehabilitation services for these women and their children who enter the program. Operation PAR coordinates its program services with the local health department, a local hospital pediatrics department, child protection teams, the local juvenile court, and drug treatment systems.

OSAP has joined with the Office of Maternal and Child Health to fund a new demonstration grant program that focuses on model programs for pregnant and postpartum women and their infants. This joint effort builds on specific agency expertise—the Office of

Maternal and Child Health's expertise in the development of perinatal health components and OSAP's expertise in prevention and early intervention services with high-risk substance abusing populations. As has been pointed out previously, \$4.5 million is available in fiscal year 1989, \$4 million from OSAP and \$500,000 from the Office of Maternal and Child Health.

In all of our programming we promote and support the development of effective, comprehensive service systems which reflect a coordinated prevention/intervention model involving all of the different segments of the community. OSAP views itself as a partner with communities, working with key community leaders and officials to strengthen their capacity to improve the various institutions which must collaborate in an effective alcohol, drug prevention and intervention program.

One of our more advanced and successful efforts has been in San Francisco. We also have comprehensive prevention/intervention activities underway in several other cities around the country, such as Newark, New Jersey; Phoenix, AZ; Orange County, California; the entire State of Delaware; and the District of Columbia.

At the Federal level, we have joined with other Federal agencies and with a large number of national associations to address these national policy issues. As a new agency with a broad mandate to develop and disseminate prevention and early intervention models for high-risk youth and their families, OSAP has been able to develop a vigorous network of collaborative interagency projects.

In closing, let me point out that in addition to working with the Office of Maternal and Child Health, we have developed an interagency agreement with the Department of Agriculture's WIC program, as well as cooperative agreements and collaborative programs with several Federal agencies, including the Departments of Justice, Labor, Education, Housing and Urban Development, and Transportation.

Although time does not permit a detailed description, we also work cooperatively with several other agencies, including the research institutes of ADAMHA, the Department of State, the Surgeon General's Office, the Centers for Disease Control and, of course, the Office for Human Development Services.

I would be happy to answer any questions you may have later. Thank you.

Senator KOHL. Thank you, Dr. Johnson. Mr. Dunn.

TESTIMONY OF G. SCOTT DUNN, ACTING ADMINISTRATOR, FOOD AND NUTRITION SERVICES, DEPARTMENT OF AGRICULTURE

Mr. DUNN. Thank you very much, Mr. Chairman, for the opportunity to be here today to talk about the Department of Agriculture's efforts to implement the Anti-Drug Abuse Act of 1988 affecting the special Supplemental Food Program for Women, Infants and Children, or WIC.

WIC is a national program with the goal of preventing health problems and improving the health status of low income, pregnant breast-feeding and postpartum women, infants and children up to 5 years of age who are at nutritional risk. The program provides

food, nutrition education, and health and social referrals to its participants.

The foods provided by the WIC program are meant to supplement the diets of program participants. The nutrition education provided by WIC emphasizes the relationship between proper nutrition and good health. A minimum of two nutrition education contacts are required to be offered during each certification period, and during these education efforts, a wide range of topics are covered to help participants improve their eating habits, their health status and provide information on breast-feeding as an adjunct to health care. WIC refers participants to health care providers as well as other health and social service agencies.

The WIC program has long been concerned about the effect of substance abuse on program participants. The abuse of alcohol, tobacco and other drugs is included among the nutritional risk criteria used for enrolling pregnant, postpartum and breast-feeding women in WIC. In many states, warnings about the danger of the use of these substances during pregnancy are provided during nutrition education counseling.

The Anti-Drug Abuse Act of 1988 requires that the WIC program provide program participants with information on the dangers of drug abuse during pregnancy and referrals for drug abuse counseling and treatment. The law also directs the Department to conduct a study of appropriate methods of drug abuse education and to prepare drug abuse education materials for distribution to state agencies. The goal of WIC's drug abuse effort is to raise awareness about the dangers of drug abuse, especially during pregnancy, and to provide referrals for drug abuse treatment among WIC's high-risk population. The WIC program is especially targeted to low-income pregnant women, and we encourage state agencies to enroll women early in their pregnancy for the program's benefits.

This is a key element, not only to maximize the nutritional aspects of the WIC benefits, but to the extent a woman is a substance abuser, to provide for early intervention and referral services at a critical time. The Department has taken this overall issue very seriously. At the onset we have identified and approached Federal agencies with drug abuse prevention expertise or expanded responsibilities under the 1988 anti-drug legislation to ensure this coordination of activities wherever possible. This coordination is intended to minimize duplication and maximize effectiveness of our efforts to reduce the incidence of drug abuse during pregnancy.

We recognize the seriousness of the problem of drug abuse in our society today, including the tragic consequences of prenatal drug abuse. We believe that the role for the WIC program in providing drug abuse information and referral services is appropriate. WIC supports efforts to reduce the incidence of prenatal drug use by raising awareness of the danger of such use during pregnancy and facilitating referrals for treatment where such treatment is available.

This is an important part of the WIC program in conjunction with its primary mission of providing nutritious foods, nutrition education, and health care referrals to improve the health status of women, infants and children during critical periods of growth and development.

Thank you very much.

Senator KOHL. Thank you, Mr. Dunn. Mr. Brock.

TESTIMONY OF C. PETER BROCK, DIRECTOR, ALCOHOLISM AND MENTAL HEALTH PROGRAMS, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE [HEALTH AFFAIRS], DEPARTMENT OF DEFENSE¹

Mr. BROCK. Thank you, Mr. Chairman. I am delighted to be here to testify on two counts today; one, because we do recognize at DOD the extent and the severity of the problem; and two, because the issues that I am going to talk about don't get as much visibility from DOD as some of our other drug related activities do.

The Department of Defense is frequently seen in its role as providing support for some of our interdiction efforts. The most visible and the most well known of our prevention efforts has been our drug testing program, and people don't always remember that we provide health care to a tremendous number of individuals as well, either through our direct care system or through the CHAMPUS program where we are paying for care through the private sector.

I have submitted a formal statement for the record, but I would like just to comment briefly on a couple of issues and then give what I think may be some reasons for some differences in the populations that we work with as opposed to some of the other testimony you have heard today.

In the nearly 100,000 live births that we had in military facilities in the last fiscal year, we don't have evidence of a single neonate that was born in withdrawal due to drug and alcohol use by the mother. We certainly cannot rule out the presence of fetal alcohol or drug effects, but we don't know of any fetal alcohol syndrome babies that were born.

One of the main reasons for this, I think, is that there is a strong prenatal care program available both to active duty women as well as to spouses of military personnel and there is no financial barrier. I think it is also important that it is part of the main-stream health care system, it is not a secondary system. It is incorporated into their health care.

Physical fitness is a big issue among the military, and so they are constantly being given messages about this. Our health care providers, physicians, nurses, other members of the team, tell pregnant women not to use any drugs—that is the message we are giving—without the express consent and knowledge of their provider. We have an educational program that we are able to take advantage of, again, with no financial barrier on their part, and no vocational barrier for active duty personnel. They are released from duty. That is seen as a legitimate and reasonable alternative to their being at their duty station.

Women who use legal substances—and by the way, the physicians talk to our women not only about the illegal drugs but about over-the-counter preparations, about prescription drug use, and advise them or urge them not to use anything without their express knowledge and consent.

¹ See p. 134 for Mr. Brock's prepared statement.

Where alcohol and tobacco are concerned, if they use them at all, they are encouraged to abstain for the period of their pregnancy. There are programs that are offered them to support that abstinence if that appears to be necessary. If they need the support of a smoking cessation program, or if they are determined to have a pattern of alcohol use that requires more than just a decision, those programs are available to them. This is only an inferential relationship, but a 1986 obstetrical outcome study that we did showed that DOD live births had a significantly lower percentage of low birth weight babies compared to the national statistics. It was only about half what it was nationally. And I think a lot of that is due to the economics and the medical care available.

We have a number of other programs both for the women and for the children, and I would be delighted to answer questions about those later if time permits. Thank you.

Senator KOHL. Thank you, Mr. Brock. Thanks for your brevity. Mr. Forsberg.

TESTIMONY OF JAMES N. FORSBERG, COORDINATOR, SPECIAL NEEDS ASSISTANCE [HOMELESS] PROGRAM IN COMMUNITY PLANNING AND DEVELOPMENT, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT¹

Mr. FORSBERG. Thank you, Mr. Chairman. I have submitted written testimony. I would like to just summarize some of those key points if I might.

Secretary Kemp has developed two priorities for the Department of Housing and Urban Development relevant to the issues that you are discussing here today. One is ending the tragedy of homelessness, and the second is eliminating drugs in our housing programs.

When Jack Kemp first became Secretary, he visited inner cities across the Nation to see the challenges we face as we work to create jobs, opportunities and decent drug free housing for every American. These visits pointed to a very tragic fact: in public housing projects throughout the country, drug abuse and drug dealing are threatening the health and safety of the residents and undermining the Department's ability to effectively manage these projects.

We intend to do everything possible to support those housing agencies and tenant managers who are determined to rid their communities of the scourge of drugs. Together with Mr. Bennett and Attorney General Thornburg, Secretary Kemp has announced a 10 point program to fight drugs in public housing.

First, we intend to tighten security; second, we will waive unnecessary Federal lease and grievance rules to evict tenants engaged in illegal drug activities; third, we are asking U.S. Attorneys to seize apartments of drug dealers and users and return them to legitimate law abiding tenants; fourth, we are reclaiming vacant units for legitimate purposes; fifth, we would like to see localities enforce housing code standards to make our units livable and hab-

¹ See p. 142 for Mr. Forsberg's prepared statement.

itable. We are encouraging resident management and home ownership efforts. Secretary Kemp has asked Kimi Gray of the Kenilworth-Parkside Project and other tenant management leaders to tour with him and teach residents how to remove drug dealers and manage projects.

Seventh, we will establish an anti-drug hotline at HUD for residents to report drug-related criminal activity; eighth, effective immediately for Section 8 rent vouchers or certificates, we will terminate the participation of persons convicted of drug crimes; ninth, we will use the anti-drug pilot program using modernization funds to support anti-drug efforts; and finally, we will support organized recreational activities for youth in our public housing.

Mr. Chairman, as HUD aggressively pursues its objective of eradicating drugs from housing programs, we will not do so at the expense of individual tenants' rights. The Secretary has directed that we carry out this policy on a case-by-case basis with compassion and consideration for innocent victims. Kinship and association are not automatic grounds for anyone's eviction. And in Secretary Kemp's recent notice implementing provisions of the 1988 Anti-Drug Abuse Act, he gave very explicit guidance that the act does not restrict the public housing authorities from exercising wise and humane judgment, weighing the interest of all concerned.

When considering action against residents involved in drugs, public housing authorities have the discretion to weigh the seriousness of the offense, the participation by other family members, the situation at the project, and the effects of eviction on other family members. And furthermore, no tenant may be evicted without the opportunity for a fair hearing in court.

In addition to the problem of drugs in public housing, we are concerned with drug abuse and its relationship to homelessness. Drug abuse is emerging as one of the major causes of homelessness. In a recent article in the New York Times, Robert Hayes, Director of the National Coalition for the Homeless, was quoted as saying that, "Drug treatment is becoming as important to the homeless as is housing."

National figures indicate that 30 percent of the homeless are probably suffering from either drug or alcohol abuse and another 30 percent have some sort of mental disability. Overall, 40 to 50 percent of the homeless are afflicted with one or another of these problems.

Although HUD is not expert in the areas that you are dealing with here today, we do have three homeless programs which we think can be used to address the problems you are dealing with. We have an Emergency Shelter Grants Program which is designed to deal with those emergency situations. We have a Transitional Housing Program which is used to build a bridge between the homelessness and independent living, and third, a Permanent Housing for the Handicapped Homeless Program.

The important element of all of this is that each of these contains an element for supportive services. HUD does not prescribe the kind of services to be provided or the needs to be addressed, but we leave that, really, to the local provider and encourage local people to work together to decide which need are most critical and must be addressed.

We are also working with the Department of Health and Human Services under the auspices of our Interagency Council on the Homeless to identify barriers to making our programs work more effectively and support one another. We intend to do all we can to make our programs work and respond to these needs. Thank you.

Senator KOHL. Thank you, Mr. Forsberg.

I will attempt to be brief. We will give Senator Levin a chance to ask you questions before we break for lunch.

Ms. GALL. Should battered women shelters serve as an entry point for alcohol and drug treatment services?

Ms. GALL. Senator, I hope we could do it before women have to enter those kinds of facilities. I hope that we can provide those kinds of help for our women early on before they have to enter those kinds of facilities. But certainly that is one area where we could provide those kinds of care for women.

Senator KOHL. Given the dire consequences for mothers and infants with respect to maternal substance abuse, is there a need for an interagency task force?

Ms. GALL. Senator, I think it is pretty clear that we all need to work together pretty closely. I am glad to see there is someone here from HUD today. We have had some recent conversations with HUD about housing concerns for foster care children and families in general. As I said previously, the biggest issue we have to face in foster care these days is drug abuse and the relationship of drug abuse to the children coming into care. Of particular concern is the relationship of drug abuse to reunifying these children with their families, which is always the first goal when children are brought into care, to reunite them with their families. Certainly housing is a compelling issue in that reunification. And so we have begun working very closely with HUD on that particular issue and we will be working with other departments and agencies as well.

Senator KOHL. Thank you.

Ms. GALL. One of the things that concerns me, Senator, is that when we take a look at these issues we always compartmentalize. We have child abuse over here, we have drug abuse over here, and we have other programs over here. And I think it is pretty clear to all of us that these are cross-cutting issues and we have to take a cross-cutting approach to those issues.

Senator KOHL. Agreed, thank you. Dr. Johnson, how much would it cost to fund fully the grant applications you are in the process of reviewing for your joint project with Maternal and Child Health targeting pregnant, addicted women?

Dr. JOHNSON. Let me say that for these grants under review, we just completed the review last week, on Friday. And we received 135 applications. I cannot give you the precise numbers at this point in time of how many were actually approved, generally, about half are approved. Each grant requires somewhere in the neighborhood of \$250,000 to fund, so if you multiply approximately 70 grants by \$250,000 per grant, an estimate of roughly \$17.5 million to fully fund the approved grants.

Senator KOHL. When you say you are reviewing these projects, is that because not all of them are important, or because you have to establish a priority in terms of which ones can you afford to fund?

Dr. JOHNSON. That is right. We received 135 applications for this grant program and then convened peer-review panels to look at them, panels contained experts in the field, from obstetrics and gynecology, as well as social workers and counsellors and so forth. These experts reviewed the proposals to determine whether or not they could meet the goals and objectives of the program.

Proposals are given priority scores if they are approved. And we look at these priority scores and at the specific programs and then determine, based upon our availability of funds, what we can fund.

Senator KOHL. Thank you. Mr. Dunn, what have been the experiences of your local WIC offices in referring drug addicted women to drug treatment programs?

Mr. DUNN. As women come in and apply for WIC benefits, they do go through a screening process to determine whether they are at nutritional risk. It is the primary emphasis that is placed in the WIC program in making benefits available. If it comes out through the discussions and the screening process, or if the woman indicates that she is a user of alcohol, tobacco, drugs, et cetera, there are nutrition education materials and other information materials available on those topics, which we provide to the women so that they can stop using those particular items, as well as referring the women to other health care services as the individual case may necessitate.

Senator KOHL. Thank you, Mr. Dunn. Mr. Brock, you mentioned the Family Advocacy Program. How important is that coordinated program to combating substance abuse, family violence and child abuse within military families and what lessons do you think we can learn from your Coordinated Family Advocacy Program?

Mr. BROCK. I think they have been very important, Senator. First of all, the families, themselves, the family members recognize that this is exactly what the name implies, it is their advocate within the system. These people have been sensitized to the fact that certain kinds of problems frequently occur in the presence of other kinds of problems and it is important that they look at the total situation that a troubled family may be experiencing rather than having, as we have heard described, this compartmentalized approach.

They then have the ability and the authority to refer these people to as many different places within the system as they may need to require help at the same time that they retain an advocacy role in being sure that those people don't either get dropped between the cracks or don't get lost in this bureaucratic miasma that can frequently overwhelm an unsophisticated—can frequently overwhelm a sophisticated person, for that matter.

But I think it has been very important that these people have one resource they know they can turn to and that this resource has been charged and has been trained to look at all of the problems and not simply at that portion for which they have been given specific responsibility.

Senator KOHL. Thank you. Mr. Forsberg, a number of witnesses on the first panel highlighted the critical need for housing, both for treatment and for transitional purposes for substance abusing mothers.

How might your Department be able to help out in this respect?

Mr. FORSBERG. Of course, the Department has its traditional housing programs, the public housing program which we are in the effort of trying to improve and bring back to occupancy a lot of the units right now that are uninhabitable. I think that is a major resource that we need to deal with.

We have our Section 8 programs. Under the homeless programs, as I said, a major program that we have to provide housing would be the Transitional Housing Program, which will provide units through rehabilitation for occupancy up to 24 months, provide all the needed services to try to enable people to move on to independent living. We also have a program for permanent housing for the handicapped, both mental and physical, which is administered by us as well.

So those are some resources I think that we have that can try to address both of those issues.

Senator KOHL. Thank you, Mr. Forsberg. Senator Levin?

Senator LEVIN. Thank you, Mr. Chairman. Dr. Johnson, I understand that the Drug Abuse Act of 1988 set up a demonstration program for the funding of treatment facilities for pregnant drug addicts, and it is that program that you are administering. Is that correct?

Dr. JOHNSON. That is correct; those are the grant applications that I just described.

Senator LEVIN. Would it be fair to say that there may be 400,000 babies born a year to substance abusing women? Is that approximately an accurate number, do you think?

Dr. JOHNSON. If you look at the total number of babies born annually, it is approximately 3.7 million. If you look at the conservative estimate of substance abuse during pregnancy that was revealed in the NAPARE study conducted by Dr. Chasnoff, it showed an overall incidence of about 11 percent. If you then take 10 or 11 percent of the 3.7 million, you come to somewhere in the neighborhood of 375,000.

Senator LEVIN. Is it a fair estimate that perhaps 15 percent of those babies, maybe up to 25 percent, are going to require some extra hospital stay upon their birth because they have been born prematurely?

Dr. JOHNSON. That is true.

Senator LEVIN. Have you ever seen the number on the cost just for the care of premature babies, what it costs this society for babies who are born prematurely because of cocaine addiction of the mother?

Dr. JOHNSON. There have been a range of estimates, and I think the low end of the range was somewhere around \$30,000 per infant.

Senator LEVIN. Per child?

Dr. JOHNSON. Per child.

Senator LEVIN. So that if you have 400,000—what was the number per child that you just mentioned?

Dr. JOHNSON. \$30,000. That is an estimate, because there is a range of estimates.

Senator LEVIN. I am not sure your math and our math come out the same, but our estimate is that it would be roughly \$3 to \$5 billion per year just for the cost of the hospital care for premature infants born to crack addicted mothers.

Dr. JOHNSON. That is true. That estimate comes from the Office of Technology Assessment which came up with the same number.

Senator LEVIN. Do you know how much money is made available per year for the treatment of crack addicted mothers?

Dr. JOHNSON. Treatment of—

Senator LEVIN. Women who are crack addicted. Do we know about how much money is available per year for treatment?

Dr. JOHNSON. No, I cannot give you the specific numbers just for that particular population. The block grant that is awarded to states for all substance abuse treatment is several hundred million, but that covers the total population. It would be difficult to estimate what the specific number would be. I would think that only a very small percentage of pregnant women receive treatment from the block grant since, in general, many programs turn these women away.

Senator LEVIN. If you can supply a specific estimate for the record, it would be helpful. But is it your testimony that it would be a very small fraction of that amount that would be available now for drug treatment of those pregnant women?

Dr. JOHNSON. I would like to look at those figures and supply an estimate for the record.

[The information referred to follows:]

The Alcohol, Drug Abuse and Mental Health Block Grant of the Federal Government currently provides \$765 million in Fiscal Year 1989 to the States for treatment and prevention services. Of this, \$545 million—approximately 70 percent—is used for alcohol and other drug abuse problems. The governing legislation requires that 10 percent, at minimum of the total \$765 million—or \$76.5 million—be spent on alcohol and other drug programs for women, especially women with dependent children, and on demonstration projects. In addition, it has been estimated that approximately one-quarter of individuals in treatment are women. Thus, the States may be funding treatment for women at levels above the 10 percent required by law. However, it is impossible to tell from the minimal information currently submitted by the States exactly how much substance abuse treatment money is spent on pregnant women. It has not been possible to determine the percentage of funds spent on alcohol versus other drug treatment, and it is not known that percentage of the women treated are pregnant, or even of child-bearing age. There is also very little data on funding for prevention and education activities.

In general, the Federal Block Grant monies account for approximately 15-20 percent of the total amount of funds spent on treatment in the nation. Thus, over 80 percent of treatment funds come from State, local, county, third-party, or other funding sources, from which even less data is available.

Senator LEVIN. Would it be your best guesstimate at this moment that it would be a fairly small fraction of that \$3 to \$5 billion?

Dr. JOHNSON. What I could look at is the number of women in treatment of child-bearing age. And that would be an estimate. And then I could look at some of the specialized programs that are treating women who are using drugs during pregnancy and give you that number. And so I could give you some estimates for the record.

Senator LEVIN. Would you have any guesstimate right now that it might be less than half of that amount of money? Do you think there is a billion and a half dollars available for the drug treatment of pregnant women who are addicts?

Dr. JOHNSON. I would say no.

Senator LEVIN. Do you—either you or Ms. Gall or anybody else—know what the budget request for this type of treatment program

for pregnant addicts was? Do you have any idea of what that request was?

Dr. JOHNSON. For the demonstration grant program that we have in place now we have been appropriated \$4.5 million for 1989. And in our budget for 1990 it is around \$4 million for new grants.

Senator LEVIN. \$4 million.

Dr. JOHNSON. \$4 million.

Senator LEVIN. This is a \$3 to \$5 billion cost. We are just talking about the hospital stay for the preemies, not anything beyond that, just the hospital stay for babies born prematurely because their mothers are addicts. Just for that short stay, we are talking \$3 to \$5 billion in annual cost in this society.

I think our Chairman perhaps has gone into some of these numbers and, I am sure, made that point this morning several times. But it is something that not only is the Administration is morally obligated—putting aside the practical reasons—to address, but so is the Congress.

These priorities that are established that some of us sometimes object to are priorities that are ultimately adopted by the Congress, not just by the Administration. So this Nation's priorities right now are not just this particular President's priorities, but they are this Congress' priorities too. So we have some responsibility on ourselves as well as pointing out what is missing from the budget in terms of funding for critically needed programs.

Dr. JOHNSON. Let me add, in addition to what I said about OSAP's demonstration grant programs, that the other public health service agency, the Health Services Resources Administration's Office of Maternal and Child Health also really has the lead responsibility for issues relating to infant mortality. So we would have to also factor in their—

Senator LEVIN. Pull together all of the agency's efforts and see if you can estimate what the State and local effort that might be available in this area is, and give a ballpark estimate, pull together some numbers and let's see just how much we are dedicating to this one little piece of this terrible tragedy. I think it is going to come out pretty much the same, that we are addressing just a tiny portion of the cost that is inflicted upon—putting aside the babies—inflicted upon society by our not treating pregnant mothers, and compare that to what it costs us just for the extra hospital stay for the premature babies. It is a terribly unwise noninvestment.

Dr. JOHNSON. I would be happy to do that, and I will try to separate out the prevention, education and treatment from the strictly health care costs as well.

Senator LEVIN. Thank you.

Senator KOHL. Thank you, Senator Levin.

Senator LEVIN. Thank you, Mr. Chairman, for what you are doing here this morning.

Senator KOHL. And just to add on, Senator Levin, the cost of supporting those people throughout their lives—when they are not able to be fully productive members of our society—that is another enormous cost.

Senator LEVIN. That is a multiplier which is, you know, hundreds of that, but if you just look at that short term 30-day cost for

that premature baby, just that little first—I mean, even then the cost of treatment is far less than what we know we are going to spend 30 days after that baby is born. Just then.

You add the lifetime cost, medical and otherwise, you are talking astronomical. But if we would just take a look at that little first month or 2 months when we know those premature babies, we know how many they are, we know what it is going to cost us, we know what the average cost is, and that is something very easy to get your hand on.

Thank you, Mr. Chairman.

Senator KOHL. Before we wrap it up, I would like to ask you a question, Mr. Dunn. Mr. Wilson had talked about a situation that I also wanted to bring up with you. What is the effect, Mr. Dunn, on your local WIC programs of threatening pregnant addicted women with prison or losing their children?

Mr. DUNN. Certainly, Mr. Chairman, nothing that we would do in the WIC program would have any kind of direct effect on those kinds of situations. Our main interest in the program is to get nutrition and health information to the pregnant woman and the infants and children that are enrolled in the program to receive those benefits.

That is what the primary focus of WIC is all about, it is to make sure that there is access to the health services clinics in the area, that they receive the benefits from the WIC program, which is food vouchers to buy certain specific tailored foods, and to make sure that the nutrition and health information is available to those women.

Senator KOHL. Do you take the position that punitive actions asserted or in fact implemented tend to keep women out of the social service system?

Mr. DUNN. One would certainly think that if it were known that there was going to be certain specific actions that could result from providing information that could be a concern. But that is up to the State and local agencies that administer the WIC program—the USDA itself does not administer the program—State and local agencies do, and they do so with a great deal of flexibility as to how they would want to structure their program. And that is something that is at the discretion of State and local WIC agencies as to how they would like to operate their program.

Senator KOHL. Thank you. Senator Wilson?

Senator WILSON. Thank you very much, Mr. Chairman. I apologize that I had to go back to my office for an appointment and missed the statements of the members of this panel. I have read some of the testimony that they submitted though.

Let me ask Secretary Gall, at page 5 of your testimony regarding Head Start, you have mentioned that 20 percent of Head Start children are requiring special services as a result from drug use, presumably, of a parent or guardian.

As some of the crack babies of a few years ago are just now entering the Head Start program, what efforts, if any, have been undertaken to identify and to study developmental disabilities these children might have that are traceable back to prenatal drug use?

Ms. GALL. Senator, we do know that drug abuse has an important impact on some children coming into the Head Start program.

Some of these children have AIDS, some of these children have developmental delays as a result of crack. I don't have any estimates at my fingertips. I would be happy to get back to you on the specific information that you are asking for.

But certainly we recognize this as a growing problem for our Head Start population and we are working now with the Substance Abuse Office and others at HHS to work with our Head Start staff, with parents and the others involved in this operation to heighten their awareness of drugs and to help them identify assistance in their local communities. That is all part of Head Start's social components, to help people identify any facilities and any community services that would help them address the drug issue in their particular families.

Senator WILSON. It strikes me that we have two responsibilities to these children. One is to provide as much assistance as we can to the children themselves. The second is that if they can be identified and if the diagnosis of their disability is indeed traceable back to prenatal drug use, it seems to me that we may be able to learn a great deal from them.

Ms. GALL. Right.

Senator WILSON. These children will provide a tremendous amount of information for physicians and child development specialists. If we are to take heed of the remarks of Dr. Fuller from the prior panel regarding behavior as concerned with the social manifestations of the injury caused by that prenatal drug use, I think they are going to have an awful lot to tell us.

Ms. GALL. We do know that some of the children coming into Head Start have problems that are drug-related. I will be happy to get back to you further on the relationship of crack, in particular, to those children.

Senator WILSON. Let me try to be a little bit more specific. Has there been an effort yet made by the administrators of Head Start to design a program to identify drug-exposed babies and trace their developmental disabilities and how they respond to treatment?

Ms. GALL. No, Senator, nothing specific as relates to crack children, and certainly that is something that we can take a look at.

Senator WILSON. I would seriously urge that you do so, because I think there is a tremendous amount to be learned.

Ms. GALL. We will be happy to take a look at that and get back to you on it.

Senator WILSON. Thank you. Let me just ask a general question of Dr. Johnson.

Could you tell me what Federal programs currently exist to combat prenatal drug use and does the Office of Substance Abuse Prevention have either in being, or prospectively, a plan of action to address this issue?

Dr. JOHNSON. Yes, within the Alcohol, Drug Abuse, and Mental Health Administration, there are two programs. One is a research program administered by the National Institute on Drug Abuse that looks at the effects of maternal drug use on the developing fetus. That is a research program.

And the Office for Substance Abuse Prevention, the fourth bureau-level organization at ADAMHA, has the responsibility for a demonstration grant program that addresses prevention, education

and treatment services for pregnant women and postpartum women and their infants. We have \$4.5 million for this program.

In addition to that, OSAP has high-risk youth demonstration programs, which are mainly dedicated to youth at risk for drug abuse, but a few of these address pregnant women and postpartum women and their infants.

Senator WILSON. That number has been criticized this morning, as you have heard. I am sure that you probably are the first one who would like to see program funding increased.

We have also heard this morning that by virtually every index that has been used to try to measure the magnitude of the problem, those that engage in that activity are convinced that the incidence is vastly underreported.

Given those constraints, I would like you to address the adequacy of the funding. I suppose to do that we would really have to be clear as to the extent to which the Office is going to be involved in activities other than research.

The legislation that I am introducing would authorize \$50 million for State grants, which is about 10 times the current demonstration grant budget.

I wonder whether your budget request contains suggestions for funding recommendations? I assume that you have the normal wars with OMB that everyone else does. I am probably asking you an impossible question to answer. I should probably have let it be rhetorical.

If you have anything that you feel relevant by way of response, please make it.

Dr. JOHNSON. Let me say that the program that we have is a very small program and the requirement is that we fund components of comprehensive programs. So the \$250,000 per program that we are estimating covers a component of a comprehensive program. In addition, it is a requirement that 10 to 15 percent or more be set aside to evaluate the effectiveness of the program. So I don't want to leave you with the impression that we believe that \$250,000 would provide a comprehensive program; it would provide only a component of that.

Senator WILSON. Thank you. Mr. Chairman, I will conclude. I want to thank you not only for holding the hearing, but also for indulging me. I think that this hearing has been one of the better that I have observed in my time in the Senate and I congratulate you on it.

Senator KOHL. Well, thank you, Senator Wilson. I want to express my deep appreciation to you for all the attention and time you have given to this and for the obvious interest you have in the problem. I would be very much interested in seeing a draft of your bill and, again, I thank you for spending such a big part of your day at our hearing.

And I would like to thank you all for being here today. Your contributions are deeply appreciated and make a real positive contribution to our effort to look at this problem, understand it and deal with it. So we thank you for your forbearance in being here and thank everybody for being here. This hearing is now closed.

[Whereupon, at 1:30 p.m., the hearing was adjourned subject to the call of the Chair.]

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Thomas
Jefferson
University

Jefferson
Medical
College

APPENDIX

Department of Pediatrics
Family Center Program

Philadelphia, PA 19107
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JULY 31, 1989

TESTIMONY BEFORE THE SENATE GOVERNMENTAL AFFAIRS COMMITTEE

GOOD MORNING SENATOR KOHL AND MEMBERS OF THE GOVERNMENTAL AFFAIRS COMMITTEE. MY NAME IS TERRY HAGAN. I AM PROGRAM AND CLINICAL COORDINATOR AT FAMILY CENTER, THOMAS JEFFERSON UNIVERSITY HOSPITAL IN PHILADELPHIA, PENNSYLVANIA. FAMILY CENTER'S DIRECTOR, DR. LORETTA FINNEGAN HAS ASKED ME TO SPEAK FOR HER, AS SHE IS IN COPENHAGEN, DENMARK, AT THE UNIVERSITY HOSPITAL, AS A VISITING PROFESSOR. WE APPRECIATE THIS OPPORTUNITY TO TESTIFY AND TO EXPLAIN THE FAMILY CENTER TREATMENT AND PREVENTION APPROACH CONCERNING THE MYRIAD OF PROBLEMS ASSOCIATED WITH ADDICTION AND PREGNANT WOMEN.

FAMILY CENTER IS AN OUTPATIENT VOLUNTARY PROGRAM DESIGNED TO PROVIDE INTENSIVE MEDICAL AND PSYCHOSOCIAL SERVICES TO DRUG AND ALCOHOL DEPENDENT WOMEN WHO ARE PREGNANT. THIS MULTI-MODALITY TREATMENT PROGRAM ENDEAVORS TO FACILITATE THE BEST POSSIBLE PHYSICAL, PSYCHOLOGICAL AND SOCIOLOGICAL OUTCOMES FOR BOTH MOTHERS AND INFANTS.

COMPREHENSIVE MEDICAL SERVICES AT FAMILY CENTER INCLUDE A PRENATAL CLINIC WHICH IS STAFFED BY OBSTETRICIANS SPECIFICALLY TRAINED IN THE FIELD OF ADDICTION AND HIGH RISK PREGNANCY. INFANTS EXHIBITING WITHDRAWAL ARE TREATED IN THE NEWBORN NURSERY BY OUR NEONATAL PHYSICIANS.

A WIDE RANGE OF PSYCHOSOCIAL SERVICES ARE OFFERED. THOSE SERVICES ARE COMPRISED OF TWO COMPONENTS: EDUCATION AND TREATMENT. THE EDUCATIONAL FOCUS TARGETS PRENATAL AND PARENTING COURSES, AS WELL AS AIDS COUNSELING. TREATMENT AIMS ARE DIRECTED AT DEVELOPING PERSONAL RESOURCES IMPROVING FAMILY AND INTERPERSONAL RELATIONSHIPS; REDUCING AND ELIMINATING SOCIALLY DESTRUCTIVE BEHAVIOR; AND FACILITATING THE PARENTAL/CHILD BOND.

OVER THE LAST TWENTY YEARS OF OPERATION, WE HAVE FOUND THAT WE CAN REHABILITATE A SIGNIFICANT NUMBER OF WOMEN WHO HAVE COME TO US DURING PREGNANCY. MOREOVER, IN METHADONE- MAINTAINED PREGNANT WOMEN, WE HAVE BEEN ABLE TO REDUCE THE INCIDENCE OF LOW BIRTH WEIGHT INFANTS FROM NEARLY 50% TO 18%. THIS REDUCTION IS SIGNIFICANT IN TERMS OF MEDICAL COSTS. PRESENTLY, A TWO POUND INFANT WILL ACCRUE MEDICAL EXPENSES TOTALING APPROXIMATELY \$150,000. RESEARCH AT FAMILY CENTER HAS RESULTED IN SUCCESSFUL TREATMENT PROTOCOLS FOR INFANTS UNDERGOING WITHDRAWAL. OUR LONG-TERM STUDIES INDICATE THAT THE PROVISION OF PERINATAL SERVICES TO THIS VERY HIGH RISK POPULATION RESULTS IN INFANTS AND CHILDREN WHO ARE DEVELOPMENTALLY, NEUROLOGICALLY, AND PHYSICALLY NORMAL.

FAMILY CENTER ALSO RECOGNIZES THAT ADDICTION IS MORE THAN A MEDICAL ISSUE. OUR RESEARCH DEMONSTRATES THAT MANY ENVIRONMENTAL VARIABLES CONTRIBUTE TO ADDICTIVE BEHAVIORS. FOR INSTANCE, ONE FAMILY CENTER STUDY COMPARED DRUG ADDICTED AND NON-ADDICTED WOMEN FROM SIMILAR SOCIOECONOMIC BACKGROUNDS. THERE WERE SIGNIFICANT DIFFERENCES IN THE FOLLOWING AREAS: NEARLY 70% OF THE DRUG DEPENDENT WOMEN EXPERIENCED EARLY SEXUAL ABUSE (BEFORE AGE 16). IN THE NON-ADDICTED WOMEN, FIFTEEN PERCENT HAD BEEN ABUSED SEXUALLY. EIGHTY-THREE PERCENT OF THE DRUG DEPENDENT WOMEN HAD A CHEMICALLY DEPENDENT PARENT. SEVENTY-FIVE PERCENT OF THOSE PARENTS WERE ALCOHOLIC. IN CONTRAST, 35% OF THE NON-ADDICTED WOMEN HAD A CHEMICALLY ADDICTED PARENT. THE FAMILIES OF THE DRUG DEPENDENT WOMEN HAD HIGHER LEVELS OF FAMILY CONFLICT, PHYSICAL VIOLENCE, AND LOWER LEVELS OF FAMILIAL COHESION.

PRESENTLY, 10% OF OUR WOMEN AND THEIR CHILDREN ARE HOMELESS. WELL OVER 50% EXPERIENCE PERIODIC PROBLEMS WITH HOUSING. OTHER SOCIAL PROBLEMS INCLUDE ILLITERACY, CRIME, UNEMPLOYMENT AND DISEASES ASSOCIATED WITH IV DRUG USE AND POVERTY.

TREATMENT MUST RESPOND TO EACH AND EVERY ONE OF THE MEDICAL AND SOCIAL VARIABLES WHICH COMPLICATE ADDICTION AND RECOVERY. FOR INSTANCE, WHILE METHADONE MAY ENCOURAGE A HEROIN-FREE EXISTENCE, AND ASSISTS IN THE PROVISION OF HEALTHIER INFANTS, IT DOES NOT ANSWER THE SOCIAL PROBLEMS FACED BY THE FAMILY CENTER WOMAN. RELAPSE IS IMMANENT WHEN DAILY SURVIVAL IS AT RISK. OUR COCAINE PREGNANT MOTHERS PRESENT US WITH CORRESPONDING COMPLEX SOCIAL ILLS, AS WELL AS THE SAME KINDS OF MEDICAL PROBLEMS WE USED TO SEE IN OUR HEROIN POPULATION: ABRUPTIO PLACENTAE, STILLBIRTHS, DECREASED INFANT BIRTH WEIGHT, DECREASED INFANT HEAD CIRCUMFERENCE AND LENGTH.

DUE TO THE COMPLICATIONS ASSOCIATED WITH ADDICTION, WE SUGGEST THAT ENERGIES CONCERNED WITH TREATMENT AND PREVENTION NEED TO BE DIRECTED TOWARDS HOUSING AND EDUCATION. FOR EXAMPLE, WE ARE SPECIFICALLY SEEKING MONIES IN ORDER TO HOUSE 50 COCAINE ADDICTED WOMEN AND THEIR CHILDREN. WE HAVE DESIGNED A HOUSING PROGRAM WHICH WOULD PROVIDE INTENSIVE DRUG AND MEDICAL TREATMENT, AS WELL AS AN EXTENSIVE EDUCATIONAL AND JOB TRAINING COMPONENT. THIS WOULD ALLOW US TO EXAMINE THE SIGNIFICANCE OF HOUSING, COMMUNITY, EDUCATION, AND JOB TRAINING ON DRUG USE. IN ADDITION, WE SHOULD BE ABLE TO INFLUENCE THE DEVELOPMENT AND SOCIALIZATION OF THE CHILDREN INVOLVED IN THE HOUSING PROGRAM. THIS KIND OF PROJECT COULD SERVE TO ELIMINATE THE MEDICAL AND THE SOCIAL PROBLEMS EXPERIENCED BY THE DRUG DEPENDENT WOMAN AND HER CHILDREN.

I WANT TO UNDERLINE FOR THIS COMMITTEE TODAY, THE DEBILITATING NATURE AND THE LONG RANGE INTERGENERATIONAL EFFECTS OF CHRONIC DRUG ADDICTION. IT IS EVEN MORE DEVASTATING TO DRUG DEPENDENT WOMEN AND THEIR CHILDREN, WHO SO FREQUENTLY DO NOT HAVE THE RESOURCES FOR RECOVERY AVAILABLE TO THEM. I AM DEEPLY DISTURBED BY THE NEWLY RELEASED DEPARTMENT OF HEALTH AND HUMAN SERVICES HOUSEHOLD SURVEY STATING THAT THERE IS A SHARP DECREASE IN COCAINE USE. WHERE DID THEY OBTAIN THEIR SAMPLE? CERTAINLY NOT FROM THE FAMILY CENTER

POPULATION OF COCAINE ADDICTED WOMEN. MOST OF OUR WOMEN DO NOT HAVE TELEPHONES OR HOMES. IN ADDITION, I DO NOT THINK THAT PHILADELPHIA IS ANY DIFFERENT THAN OTHER METROPOLITAN AREAS. PLEASE KNOW THAT BECAUSE OF THE LACK OF TREATMENT SERVICES AND RESEARCH ENDEAVORS WITH THE DRUG ADDICTED POPULATION, WE ARE NOW PLAGUED WITH RAMPANT DRUG ADDICTION IN THIS COUNTRY. A RECENT STUDY FOR THE PHILADELPHIA PERINATAL SOCIETY INDICATED THAT ON THE AVERAGE OVER AN EIGHT WEEK PERIOD, 16% OF THE BIRTHS IN ALL OF THE HOSPITALS IN PHILADELPHIA WERE DRUG RELATED BIRTHS. BECAUSE OF THE INTERGENERATIONAL TRANSMISSION OF THE DISEASE OF ADDICTION, AS A COUNTRY, WE HAVE FOSTERED A SPIRALING LEGACY OF ADDICTS GIVING BIRTH TO ADDICTS. MUST THIS GENERATION AND FUTURE GENERATIONS SUFFER DUE TO OUR UNWILLINGNESS TO ACT WITH URGENCY? WE MUST MAKE A SINCERE COMMITMENT THAT TURNS THE COURSE OF THIS HUMAN TRAGEDY.

TERESA ANN HAGAN, MSW
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TESTIMONY

REED V. TUCKSON, M.D.
COMMISSIONER OF PUBLIC HEALTH
DISTRICT OF COLUMBIA

JULY 31, 1989
COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

GOOD MORNING MEMBERS OF THE SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS. MY NAME IS REED TUCKSON, AND I SERVE AS THE COMMISSIONER OF PUBLIC HEALTH FOR THE DISTRICT OF COLUMBIA. MY EXPERIENCES HAVE CAUSED ME TO BECOME INCREASINGLY CONCERNED ABOUT THE QUALITY OF HEALTH FOR THOUSANDS OF OUR CITIZENS IN THE DISTRICT AND IN URBAN COMMUNITIES ACROSS THIS COUNTRY. THE BURDEN OF DISEASES SUCH AS HEART DISEASE, CANCER, VIOLENCE, ACCIDENTS, CHEMICAL DEPENDENCY, INFANT MORTALITY, DIABETES AND HIV DISEASE CONTINUES TO INCREASE WHILE THE AVAILABLE RESOURCES TO MANAGE THEM DWINDLE.

ULTIMATELY, ALL OF THESE PROBLEMS SHARE TWO COMMON THEMES. FIRST, THEY ARE CAUSED OR EXACERBATED BY HOW WE CHOOSE TO LIVE OUR LIVES, BY OUR BEHAVIOR. HEALTH IS THE PLACE WHERE ALL OF THE SOCIAL FORCES CONVERGE TO EXPRESS THEMSELVES WITH THE GREATEST CLARITY AND THE MOST IMPORT. SECONDLY, THEY ARE PREVENTED, TREATED OR CURED BY ACCESS TO VERY BASIC, FUNDAMENTAL HEALTH CARE INTERVENTIONS. UNFORTUNATELY, THE SOCIAL, ENVIRONMENTAL AND STRUCTURAL CONDITIONS THAT PRODUCE THESE NEGATIVE HEALTH OUTCOMES CONTINUE TO STAGNATE AND THE

ALREADY INADEQUATE HEALTH CARE SYSTEM AVAILABLE FOR MOST OF THIS COUNTRY'S POOR IS NOW STRETCHED TO THE BREAKING POINT.

OUR RESPONSIBILITY, AT A MINIMUM, MUST BE TO EXTRACT MAXIMUM BENEFIT FROM ALL AVAILABLE RESOURCES, PUBLIC, PRIVATE AND PHILANTHROPIC, AND TO ENSURE THAT THEY ARE WELL DIRECTED AND COORDINATED. NO WHERE IS THIS MORE CRUCIAL THAN IN OUR EFFORT TO ADDRESS THE MULTIPLE HEALTH CHALLENGES PRESENTED BY WOMEN WHO ABUSE SUBSTANCES. THERE CAN BE LITTLE DOUBT THAT THE NUMBERS OF WOMEN WHO ABUSE DRUGS SUCH AS CRACK COCAINE AND THE RESULTANT INCIDENCE OF SEXUALLY TRANSMITTED DISEASE, HIV DISEASE, INFANT MORTALITY, AND VARIOUSLY DISABLED AND NEGLECTED INFANTS AND CHILDREN HAS, IN MANY CITIES, REACHED THE LEVEL OF A PUBLIC HEALTH EMERGENCY.

OF THE DRUGS OF ABUSE, NONE EXEMPLIFIES THE SEVERITY OF THE CHALLENGES CONFRONTING US BETTER THAN CRACK COCAINE. DESPITE DILIGENT EFFORTS BY THE CRIMINAL JUSTICE SYSTEM, THE HEALTH CARE COMMUNITY AND COMMUNITY LEADERS, THE USE OF CRACK USUALLY IN CONJUNCTION WITH OTHER DRUGS, CONTINUES TO ESCALATE. AS A CONSEQUENCE OF ITS EXTRAORDINARY ADDICTIVE PROPERTIES AND ITS EXTREMELY SHORT DURATION OF ACTION, CRACK USERS WILL DO ALMOST ANYTHING TO ACQUIRE THE DRUG. THIS INCLUDES ENGAGING IN MULTIPLE SEXUAL ENCOUNTERS WITHIN A DRUG CULTURE ALREADY INFECTED WITH THE HIV VIRUS AS A MEANS OF FINANCING OR BARTERING FOR DRUGS. THE APHRODISIAC PROPERTIES OF THE DRUG EXACERBATE THIS SCENARIO. AS A RESULT, WE NOW FIND THT THE INCIDENCE OF SEXUALLY TRANSMITTED DISEASES ARE SIGNIFICANTLY

INCREASING DESPITE AN UNPRECEDENTED NATIONAL PUBLIC EDUCATION CAMPAIGN AND CONCERN ABOUT THE NEED FOR SAFER SEXUAL PRACTICES BECAUSE OF HIV DISEASE.

OUR CONCERNS ABOUT CRACK ABUSE AND HIV DISEASE EXTEND BEYOND THE OBVIOUS RELATIONSHIP BETWEEN DRUGS AND SEXUALITY. WE NOW OBSERVE THAT MANY CRACK ADDICTS WILL USE HEROIN INTRAVENEOUSLY TO COUNTERACT THE INTENSITY OF THEIR COCAINE HIGHS. AS SUCH, WE ARE NOW IN DANGER OF CREATING A NEW GENERATION OF HEROIN ADDICTS, MANY OF WHOM WILL BECOME HIV POSITIVE. IN THE DISTRICT, 53% OF HIV POSITIVE WOMEN ARE DRUG ABUSERS AND THE OVERWHELMING MAJORITY OF OTHERS ARE THE SEXUAL PARTNERS OF IV DRUG ABUSERS. SIGNIFICANT NUMBERS OF THE WOMEN WHO ARE HIV POSITIVE ARE UNINSURED AND THEIR INCREASINGLY, INTENSIVE, EXPENSIVE, AND PROTRACTED CARE WILL FALL UPON STATE AND CITY SYSTEMS THAT ARE UNPREPARED TO ADEQUATELY PROVIDE FOR THEM.

AS SEXUAL BEHAVIOR INCREASES, WITHOUT BENEFIT OF CONTRACEPTION, SO DO PREGNANCIES. PREGNANCIES IN THIS POPULATION ARE USUALLY ASSOCIATED WITH INADEQUATE NUTRITION, INADEQUATE PRENATAL CARE AND THE TOXIC EFFECTS OF DRUGS, BOTH ON THE DEVELOPMENT OF THE FETUS AND THE EVENTS ASSOCIATED WITH CHILDBIRTH. EVERY MONTH THE AMBULANCE SYSTEM OF THIS CITY PICKS UP AT LEAST 20 PREGNANT WOMEN SO COMPROMISED BY THE EFFECTS OF DRUGS, THAT THEY REQUIRE THE SERVICES OF THE EMERGENCY MEDICAL SYSTEM. OFTEN, AT D.C. GENERAL HOSPITAL, 45 OF THE 60 BASINETTES IN THE NEWBORN NURSERY, ARE OCCUPIED BY BABIES

BORN TO SUBSTANCE ABUSING WOMEN. AT GREATER SOUTHEAST HOSPITAL THE EXPERIENCE IS 33%, AT HOWARD UNIVERSITY HOSPITAL, APPROXIMATELY 40%.

AS A DIRECT CONSEQUENCE OF THIS, AND DESPITE A VERY COMPREHENSIVE PRENATAL CARE INITIATIVE LAUNCHED BY MAYOR BARRY TWO YEARS AGO EMPHASISING FREE CARE, EASY ACCESS AND AGGRESIVE OUTREACH, THE INFANT MORTALITY RATE IN THE DISTRICT THAT HAD DECREASED TO 19.6 HAS NOW REACHED 23.2 DEATHS PER 1,000 LIVE BIRTHS. FOR THOSE INFANTS WHO SURVIVE, THE MAJORITY OF THEM, AND ALL OF US FACE LIFETIMES OF COPING WITH SPEACH AND HEARING DEFECITS, DEVELOPMENTAL PROBLEMS, LEARNING DISABILITIES AND ANATOMIC MALFORMATIONS THAT RESULT.

I WOULD ALSO BRING TO YOUR ATTENTION THE RECENT EPISODES OF TODDLERS WHO ACCIDENTLY INGESTED DRUGS FOUND IN THEIR HOME ENVIROMNENTS, A PROBLEM THAT NEEDS MUCH GREATER STUDY AND DOCUMENTATION. IN ADDITION, OUR SURVEYS REMIND US THAT TOO OFTEN, CHILDREN WHO ABUSE DRUGS ARE FIRST INTRODUCED TO THEM IN THEIR HOMES BY OBSERVING THEIR PARENTS AND, IN SOME CASES, ASSISTED BY THEIR PARENTS.

GIVEN THE DIMENSIONS, VARIETY AND MAGNITUDE OF THESE ASSOCIATED CHALLENGES, STRATEGIC COORDINATION FO ALL OF OUR NATIONS HEALTH RESOURCES TARGETED AT THE HEALTH OF WOMEN, INFANT AND CHILDREN IS MANDATORY. THIS INCLUDES NOT ONLY SUBSTANCE ABUSE SERVICES, BUT ALSO GENERAL HEALTH CARE, MATERNAL AND CHILD HEALTH, NUTRITION, HIV, HOSPITAL BASED, DEVELOPMENTAL DISABILITY, EDUCATION, RECREATIONAL, EMPLOYMENT, HOUSING AND OTHER SOCIAL SUPPORT SERVICES.

I PERSONALLY AM ENCOURAGED BY SEVERAL RECENT CONVERSATIONS WITH SENIOR OFFICIALS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES THAN CONVINCE ME OF THEIR UNDERSTANDING AND COMMITTMENT TO WORK WITH THE DISTRICT TO ADDRESS MANY OF THESE PUBLIC HEALTH EMERGENCIES.

NAPARE

National Association for Perinatal Addiction Research and Education
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July 31, 1989

CONGRESSIONAL TESTIMONY

Ira J. Chasnoff
President,
National Association for Perinatal Addiction
Research and Education (NAPARE)
Associate Professor,
Pediatrics & Psychiatry,
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Although problems of substance abuse in pregnancy have received increasing attention since the early 1970's, there has recently been a very rapid increase in the concern for the infants born to alcohol and other drug using women. The reasons for this concern are easily understood when current statistics from the National Institute on Drug Abuse are reviewed. Although patterns of abuse of alcohol, marijuana, heroin, and other substances by women of childbearing age have changed very little over the last 10 years, the incidence of cocaine use in this special population has been rising rapidly, a reflection of cocaine's increasing popularity among the general population of the United States.

EPIDEMIOLOGY

Early studies evaluating drug use by women during pregnancy revealed that around 50 to 60 percent of women used some analgesics during pregnancy, and sedative drug use by pregnant women ranged around 25 percent. Most of the women involved in studies such as these were women who were receiving prenatal care and were obtaining many of the medications by prescription from their physicians. Use of illicit drugs rarely was considered. During a 6-month period in 1982, screening of all women enrolling at Prentice Women's Hospital and Maternity Center for routine prenatal care revealed that 3 percent of these women had sedative-hypnotics in their urine at the time of admission to the general maternity clinic. This study was performed prior to cocaine's becoming society's drug of choice. Currently, with an estimated 20 million Americans having tried cocaine at least once, and 5 million using it on a regular basis, the number of pregnant cocaine users in the United States has risen rapidly. A recent study by the National Association for Perinatal Addiction Research and Education (NAPARE) of 36 hospitals from around the country showed the overall incidence of substance abuse in pregnancy was 11% with a range of 0.4% to 27%.

Studies from specific hospitals revealed the following rates:

Name/Hospital	Method	N	Percent
Little Parkland Dallas, TX	History, intake into prenatal clinic	3000	9.8 coc 3.0 amph
Roger Shands Gainesville, FL	Urine on consecutive newborns	100	10 coc
Wong San Francisco General	Urine on all NBS in one month	170	10 coc
Burkett Bandstra Jackson Memorial Miami, FL	Urine on consecutive women at L/D	300	12.5 coc
Bateman Harlem Hospital New York, NY	Urine on all NBS	3000	15 coc
Rahman Chicago Osteopathic Chicago, IL	Urine on all NBS May/June '88	158	16 coc
Zuckerman Boston City Boston, MA	History, urine on study participants	1600	17 coc 27 mj
Colmorgen Christiana Newark, DE	Urine at first prenatal visit	1500	24 all drugs
Evans University of California, Davis	Urine on every woman at L/D	800	25 coc amph her

As further studies have been conducted, we have found that rural areas of the United States have not been spared. For example, in Winatchee, Washington, 25-30 babies per week are delivered at the community hospital. Among these 3 to 4 per week are reported to the Child Protective Services team due to having cocaine in their urine at birth (Pat Boggess, M.S., Child Protective Services, Division of Children and Family Services, State of Washington). In September, we will be releasing the results of our current study in Pinnellas County, Florida, which is examining and comparing the

rates of positive urine toxicologies in pregnant women in private obstetric care versus pregnant women in public health clinics. In New York City, it was estimated that 50 percent of all child abuse and neglect cases involved drug abuse, and if alcohol was included, substance abuse was involved in 64 percent of child abuse cases. In a survey conducted by the Child Abuse Prevention Program, Department of Health Services In Los Angeles, California, of a total of 5973 cases of child abuse reported in 1985, 538 cases (9 percent) involved neonatal withdrawal due to maternal drug use in pregnancy. In the first 6 months of 1986, 403 of 4299 cases (9.4 percent) of child abuse were reported due to maternal addiction during pregnancy. The patterns of drug use in this population showed a shift toward a higher frequency of cocaine use among the reported cases in the first 6 months of 1986 as compared to 1985.

In 1985, Illinois child welfare professionals began to express growing concern over the large numbers of alcohol dependent families in their caseloads. In order to gain some perspective on the extent of the problem in Illinois, several surveys were undertaken. Initially, experienced supervisors were selected on a random geographical basis and asked to indicate the percentage of neglect cases in which parental alcoholism or drug dependence was a problem. Between July 1, 1985 and March 1, 1986, over 11,000 cases of neglect had been reported which included parental alcoholism and/or drug dependence as problems. Further, they also reported that in 75% of the cases, alcoholism was the mother's problem rather than the father's. Additionally, several Illinois alcoholism treatment programs were contacted to determine the percentage of women served in their program who had engaged in neglectful behavior toward their children. In fact, 50% of the women had lost custody of their children prior to entering the program. The Sheltering Arms Alcoholism Treatment Program in Joliet, Illinois, reported that almost all of the women in a typical Alcoholics Anonymous meeting self reported child neglect.

A 1987 Illinois survey reported that in 50% of the families with children in placement, maternal alcohol or substance abuse was known or suspected. This figure reflects the low end of the national perspective as detailed in a 1986 Prevention Report which stated "there are estimates that as many as 50 to 75% of clients (in public agency caseloads) have an alcohol-related problem." Of course, the linkage between alcohol/substance abuse and poor parenting was not newly discovered. It had been consistently documented in the alcoholism literature for over ten years. Yet, in spite of this longstanding and well-documented linkage of parental alcoholism and child neglect, there remained a curious paucity of multi-disciplinary education/training and documented collaborations between alcoholism and child welfare professionals. These groups often worked separately within their own areas of expertise. The results were not encouraging.

NEONATAL SYMPTOMS

The fact that drugs cross the placenta and reach the fetus creates potential problems of fetal development. These problems can be manifested as congenital abnormalities. In addition, one of the important effects of maternal drug use during pregnancy, especially use of drugs with high potential for abuse, is that dependence develops in the fetus as well as the mother. Thus, the opiate-exposed fetus will experience withdrawal when the mother is withdrawn from her drug or at term when the maternal drug use no longer provides the newborn with drugs.

Symptoms of neonatal withdrawal are often present at birth but may not reach a peak until 3 to 4 days of life or as late as 10 to 14 days after birth. The most common features of the neonatal abstinence syndrome mimic aspects of an adult withdrawing from narcotics. Most significant for the neonate are the high-pitched cry, sweating, tremulousness, excoriation of the extremities, and gastrointestinal upset. Withdrawal from narcotics persists in a subacute form for 4 to 6 months after birth, with a peak in symptoms at around 6 weeks of age. Abstinence symptoms in the neonate exposed to nonnarcotic drugs in utero have been described for phenobarbital, diazepam, marijuana, and alcohol. Although withdrawal from these substances does not appear to result in as severe a syndrome of abstinence as withdrawal from narcotics, the newborn does exhibit the irritability and restlessness, poor feeding, crying and impaired neurobehavioral abilities that are characteristic of the neonatal abstinence syndrome.

The major problems facing child care workers today are associated with cocaine use in pregnancy. As in other substance-abusing populations, cocaine-addicted pregnant women have a high incidence of infectious disease complications, especially hepatitis, AIDS, and venereal disease. There is an increase in complications of labor and delivery in cocaine-using women so that precipitous delivery, abruptio placentae (usually occurring shortly after administration of cocaine), evidence of fetal monitor abnormalities, and fetal meconium staining are present in a significant number of pregnancies complicated by cocaine use. Gestational age tends to be lower for cocaine-exposed infants, and neonatal birth weight, length, and head circumference smaller when compared to growth parameters for drug-free infants. Signs of irritability and tremulousness, with an inability to respond appropriately to stimulation are often noted in cocaine-exposed neonates. The neurobehavioral changes for cocaine-exposed infants are in some areas more severe than changes noted for methadone-exposed infants.

Many of the abnormal characteristics seen in the cocaine-exposed newborn persist through at least 4 months of age. When comparing motor development of cocaine-exposed infants to non-drug exposed infants, some striking differences can be noted in muscle tone, reflexes, and movement patterns. Many cocaine-exposed infants feel stiff when their limbs are moved, and on their back often lie in excessively extended postures. Tremors are common, especially in their arms and hands, when they reach for objects.

A high rate of complications have been noted for cocaine-exposed neonates. Perinatal cerebral infarctions (strokes) have occurred in infants whose mothers have used cocaine over the few days prior to delivery. These perinatal cerebral infarctions are a severe example of the morbidity associated with intrauterine exposure to cocaine and are similar to strokes reported in adults who use cocaine. There is also evidence for genitourinary, cardiac and central nervous system malformations in infants delivered to cocaine-using mothers. Abnormalities of respiratory control, with an increase in infant apnea, have been noted in clinical studies. Most published studies of cocaine's effect on pregnancy and infant outcome have focused on recognized substance-abusing populations, and little information regarding the effects of minimal cocaine use is available.

A recent study by our group published in the Journal of the American Medical Association documented the efficacy of our early intervention model. In this study, we documented that cocaine using pregnant women who, through comprehensive medical and psychotherapeutic intervention became drug-free by the end of the first trimester of pregnancy, had a lower rate of complications in pregnancy. Specifically, successful intervention resulted in a lower rate of spontaneous abortion, premature delivery, intrauterine growth retardation, and abruptio placentae. Infants born to mothers who stopped using cocaine by the end of the first trimester had a lower rate of neonatal seizures and cardiovascular accidents. It is thus clear that the key to intervention is early recognition of the pregnant substance-abusing woman and prompt referral into substance abuse treatment.

FINANCIAL IMPLICATIONS

In fiscal year 1989, 2,500 newborns were identified as having a positive urine toxicology for cocaine in the state of Illinois. It must be remembered that a positive urine for cocaine implies two factors:

- 1) the newborn infant had symptoms which prompted the physician to order a urine toxicology, and
- 2) the mother used cocaine in the 48 hours prior to delivery for the urine to be positive in the newborn.

Thus, this screening technique misses the majority of infants, i.e. those infants whose mothers may have used cocaine throughout the pregnancy, but did not use in the last two days prior to delivery. It also misses those infants who had been exposed to cocaine but exhibited symptoms of lethargy, somnolence, and poor responsiveness, rather than irritability. Thus, the following figures are very conservative. Based on current health care costs in the state of Illinois, the following financial figures can be estimated:

HEALTH CARE COSTS FOR COCAINE-INVOLVED PREGNANCIES

	Prenatal Care	Maternal Hospital Stay (assuming no maternal complications)	Neonatal Care
	-----	-----	-----
Cocaine use with treatment	\$5000	2 days at \$500/day = \$1,000	2 days @ \$500/day \$1,000
Cocaine use, no treatment	0	2 days at \$500/day = \$1,000	Avg 20 days at \$1,500/day
Total cost for pregnancy & neonatal medical care 1st 30 days after delivery:			Treatment: \$ 7,000 No Treatment \$31,000

In Illinois FY 1989:	2500 NB with positive urine for cocaine *
Treatment:	2500 x \$ 7,000 = \$17,500,000
No Treatment:	2500 x \$31,000 = \$77,500,000
Extra cost per year:	----- \$60,000,000 -----

* identified only by urine toxicology.

It is important to realize that these figures represent only health care/medical care costs and do not include social service interventions and education costs of the children as they get older. These figures are extremely conservative given the fact that urine toxicologies at birth identify only about 1/3 to 1/4 of the infants exposed to cocaine during pregnancy. If the situation in Illinois is similar to other states, then one could project that the national cost for infants in all 50 states would be \$3 billion.

IMPLICATIONS FOR FEDERAL POLICY

Federal policy providing prevention and intervention approaches to the problems of alcohol and other drug use in pregnancy should be based on three basic concepts:

- 1) Early identification of the pregnant substance-abusing woman and provision of treatment services to bring her to drug abstinence will prevent the obstetric and neonatal complications of perinatal addiction.
- 2) The most commonly missed diagnosis in obstetric and pediatric medicine is drug use in pregnancy; thus, necessary intervention is never initiated.
- 3) Even if the diagnosis of drug use during pregnancy is made, the physicians often cannot find an appropriate treatment program that will enroll a pregnant woman.

In order to address these basic issues, models of coordinated prevention/intervention services must be developed. These services should be based on solid research information and tested through demonstration projects with full evaluation of outcome. These projects cost money; however, these monies would fall far short of the \$3 billion needed to provide care for these children after delivery in the first month of life.

Two weeks ago I had the opportunity to participate in the review of demonstration program applications submitted to the Office of Substance Abuse Prevention in answer to their request for proposals to develop programs for substance abusing pregnant and post-partum women. Applications were submitted by community, county and state governmental agencies as well as health care organizations. A total of \$35 million in requests was made, however, OSAP had only \$4.5 million available to fund these programs. The level of frustration among front line health care workers is monumental. The answer lies not in developing newer, larger, and more expensive high-tech neonatal nurseries, but to begin funding prevention and intervention programs and developing health care systems that will answer the needs of the highest risk populations. The key to intervention will be access to health care for high risk women. Thus, physicians and other health care professionals must be trained to identify substance-abusing pregnant women and initiate referral into the treatment system. The public must be assured of non-punitive, comprehensive care which will meet the needs of the pregnant woman who is a substance abuser. We need not legislate health care and we need not resort to legal and punitive action if we look upon the pregnant women as a special category of substance abusers rather than a special category of parents.



AMERICAN PUBLIC WELFARE ASSOCIATION

Ruth Massinga, President

A. Sidney Johnson III, Executive Director

TESTIMONY OF

GREGORY L. COLER

SECRETARY, FLORIDA DEPARTMENT OF
HEALTH AND REHABILITATIVE SERVICES

AND

CHAIR, AMERICAN PUBLIC WELFARE ASSOCIATION COMMISSION ON
CHILD WELFARE AND FAMILY PRESERVATION

BEFORE THE

SENATE GOVERNMENTAL AFFAIRS COMMITTEE

July 31, 1989

Good morning, Mr. Chairman and Members of the Committee. Thank you for this opportunity to testify. I am Gregory L. Coler, secretary of the Florida Department of Health and Rehabilitative Services (HRS) and chair of the American Public Welfare Association's National Commission on Child Welfare and Family Preservation.

The American Public Welfare Association (APWA) is a 59-year-old nonprofit, bipartisan, organization representing the 50 state human service departments, 800 local public welfare agencies, and more than 5,000 individuals concerned with social welfare policy and practice. Strengthening families and preventing child abuse and neglect have been, and continue to be, major APWA priorities.

APWA formed the Commission on Child Welfare and Family Preservation in 1988 to conduct an in-depth review of the public child welfare system and to propose comprehensive reforms to improve the services that are provided to vulnerable children and their families. The Commission, which is made up of 29 leading cabinet-level state human service commissioners, local administrators, and public child welfare directors from around the country, is committed to developing comprehensive community-centered approaches to meet the needs of at-risk children and troubled families, to prevent abuse and neglect, and to

strengthen families before a crisis ensues.

Today's Child Welfare Population

Substance abuse is just one factor making today's child welfare population significantly different from the children we saw 10 or even five years ago. The foster care population increasingly consists of older, more seriously troubled and frequently severely abused children; young children with serious health problems; children of drug abusing, or mildly retarded parents; and children who are mentally retarded or otherwise developmentally disabled, sometimes as a result of substance abuse by their mothers during pregnancy.

We see a preponderance of teenagers in the child welfare system at one end of the spectrum, and a growing number of seriously handicapped infants at the other.

Teenagers in the child welfare system produce a new set of problems. They are more likely than younger children to be labeled "delinquents" or "status offenders," requiring extensive involvement with the legal system. They often come from families with serious long-standing problems that require out-of-home placement, but traditional foster home settings are ill-equipped to respond to the needs of troubled teens nearing adulthood. In some cases, families are so dysfunctional that reunification is out of the question.

Children coming into the foster care system tend to

have multiple problems. In some agencies, chemical abuse is a significant factor in over 70 percent of all child welfare cases. Child abuse reports are on the rise. Domestic and criminal violence have become more and more a part of these families' lives. Sexual abuse has also become increasingly severe and has begun to be found at very early ages.

Black, Hispanic, and other minority children needing out-of-home placement represent a special population. Nationwide, nonwhite children represent only about 21 percent of children in the general population yet they make up about 47 percent of the foster care population.

Newborns and young children addicted to cocaine make up perhaps the fastest growing area of the child welfare population. Today in our largest cities one child in 10 is born addicted to cocaine. One out of three babies referred to child protective services in our cities is the child of a drug abusing parent. Crack babies are among our most challenging problems today--not only are they born premature and in many cases disabled; they are also born lacking attentive, caring parents--they are two-time victims of drug abuse. This is a major issue facing the nation and the public child welfare system.

A recent survey conducted by the National Association for Perinatal Addiction Research and Education indicates that the problem is national in scope; the situation is not confined to urban centers or areas with high concentrations of low-income people. Cocaine babies are, today, where AIDS

victims were two or three years ago. We are behind the curve on this critical situation and the problem is growing. As it does, the need for services to respond to the crisis will tax the resources of a already overburdened child welfare system.

The lack of national information on the extent and nature of drug- and alcohol-related child welfare problems has hampered efforts by policymakers, program administrators, and advocates to propose possible solutions. Accordingly, APWA recently began a survey, in conjunction with the American Enterprise Institute, to collect statistical data from state child welfare agencies on the problems of children on the child protective services (CPS) system who have drug-addicted or alcoholic parents. The results of the survey, which will be released this fall, will provide vital information both on the national incidence of substance-abuse related problems within the CPS population and on existing programs to deal with those problems.

APWA has long recognized the enormous burdens substance abuse puts on children and families, and on the human services agencies working to serve them. In its 1987 policy report, *America's Poor: America's Agenda*, the association called for increased public and private support for intervention and treatment programs aimed at aiding substance abusers, and for increased efforts to educate Americans about the dangers of drug and alcohol abuse.

Conditions in Florida

Abuse of both alcohol and drugs has been a persistent concern in the state of Florida for over 20 years. Waiting lists for treatment have grown steadily since crack cocaine and marijuana abuse reached epidemic proportions in state fiscal year 1985-1986. Today there are over 2,000 people waiting for treatment at any given point in time. Over 600 people are unable to get immediate treatment or treatment within a reasonable amount of time. As a result, they have stopped seeking services and, more than likely, are continuing their substance abusing behavior. Thirty percent of the adults waiting for treatment are women.

Florida is particularly susceptible to the illegal drug business because of its proximity to the Latin American countries that produce and export cocaine and marijuana. Florida's over 1,000 miles of coastline and numerous port areas afford many opportunities for the importation of illegal drugs from these countries. South Florida is viewed as the cocaine distribution center of the United States, with approximately 70 percent of all illegal drugs annually smuggled into the United States entering the country through Florida. According to a report by the Florida Department of Law Enforcement (FDLE), cocaine seizures in Florida amounted to 52,579 pounds in 1986, a 53 percent increase in volume over the previous year. (These seizures made up 72 percent of the total U.S. seizures of cocaine during that year.) In

1987, Florida recorded over 1 million serious crimes and had the nation's highest crime rate. Law enforcement experts estimate that 50-60 percent of all crimes are related to substance abuse (FDLE, 1987).

Since 1982, Florida has seen a dramatic increase in the problem of cocaine abuse. Statewide admissions to substance abuse treatment programs for primary cocaine use began increasing steadily long before the onset of the "crack" cocaine epidemic in 1986-87. Data from the early 1980's reveal that cocaine abuse was widespread, with the majority of users mixing cocaine, marijuana, and other narcotics. Cocaine admissions to drug abuse treatment have risen from 17 percent of admissions in 1982-1983 to over 64 percent of current admissions.

As an aside, I should point out that a significant percentage of the welfare population is substance-dependent. Federal resources to support treatment for these clients are currently insufficient to meet this growing problem. Unless steps are taken to free these individuals from their dependency on drugs, there is little hope that they will be able to reach for the chance at economic independence offered by the Job Opportunity and Basic Skills (JOBS) Training Programs states are now implementing under the Family Support Act of 1988.

The Family Support Administration has yet to indicate clearly whether drug treatment programs will be funded as support services under the JOBS program. I urge you in the

course of congressional oversight to support the inclusion of such services as part of the supports welfare clients need in order to attain self-sufficiency.

The continuing "crack" cocaine epidemic has made a high-quality, inexpensive, and easily consumable form of cocaine available to almost anyone. Children as young as 10 and 11 years old are using crack, and newborn infants are suffering the effects of crack cocaine use by their mothers.

We in the human services see the range of medical and developmental problems this scourge visits upon our children. We see miscarriages, malformed limbs, and eight-week-old babies who have not gained weight since birth. We take calls from the grandmother who is terrified that her daughter is so focused on her drug habit that she may simply forget to feed her infant daughter. We hear foster parents tell of first-graders unable to concentrate and prone to unpredictable outbursts and temper tantrums--only later do we discover that the children's mothers had used cocaine throughout their pregnancies. We see the terrible results of physical and mental abuse of children by parents too strung out on drugs to notice or care about anything.

Unfortunately, these cases are not unique, or unusually lurid or sensational. They are regular occurrences. We have been collecting information on substance-abused newborns in Florida since 1986. That fall, HRS' Alcohol and Drug Abuse Program began receiving inquiries about babies being born "addicted" to cocaine. A statewide survey of 25 hospitals

with neonatal units produced a conservative estimate of possibly 5,000 babies born throughout Florida with symptoms or evidence of exposure to drugs, primarily cocaine.

Since that time, the incidence of newborn babies exposed to illegal substances and/or alcohol has skyrocketed in Florida and has become a nationally recognized problem. In 1987, the physical drug dependency of a newborn was defined as a type of abuse under Florida's child abuse statute. People who reasonably suspect that a newborn has been exposed to substance abuse were required to report this suspicion to the Florida Protective Services Abuse Registry.

Upon notification the registry immediately contacts the child protective investigator in the area. The protective investigator immediately conducts an investigation, which includes the immediate notification of the HRS county public health unit (CPHU). The CPHU performs a pre-discharge and post-discharge health care assessment of the home, the environment, and the parent or parents' ability to care for the health needs of the child. The mother is given information on the unique needs of a substance-abused newborn.

In 1988, Florida had 2,512 infants reported to HRS county public health units for possible cocaine exposure. These cases were all reported to the Abuse Registry. Six hospitals in Florida have done studies on the urine of all newborns for a certain limited time period without identifying the babies sampled. These studies tend to

reveal that five times the number of babies reported actually have cocaine in their urine. Each quarter, 27-33 percent of these babies weighed 5.8 pounds or less. Using an average figure of \$30,000 per initial hospitalization, these babies alone cost \$21 million.

Figures for the first quarter of 1989 reveal 897 cases reported--an 54 percent increase from the number of cases reported in the first quarter of 1988. In 57.9 percent of these cases, the child's mother received no prenatal care. Estimates indicate that over 10,000 substance-exposed infants will be born in Florida this year.

This growing population poses obvious difficulties for those providing medical care to mothers and infants involved with substance abuse. Many physicians, nurses, and other health care personnel are unfamiliar with the physical and psychological effects of alcohol and drug use and are particularly inexperienced in providing obstetrical care for pregnant women who are substance abusers. Without adequate screening for substance abuse, obstetrics personnel often approach delivery unaware that the mother and newborn are at risk for serious complications during and after labor.

Unfortunately, the reporting process that is currently our main vehicle for identifying substance-exposed mothers and infants is complicated by growing legal issues. Potential prosecution, both under ordinary drug laws and under the child abuse statute makes many potential reporters reluctant to identify women as substance abusers--one

Florida woman was recently convicted for delivering cocaine to her babies through her umbilical cord. Treatment programs and medical resources estimate that many women and infants who are at risk are not being identified. This is dangerous not only for the mother and infant, but also for other members of their household, as substance abuse by the mother during or after pregnancy may create an environment of abuse and neglect for other children in the home. Although legal standards and reporting procedures are still evolving, any subtle clues or combination of risk indicators must be pursued if the health and safety of the mother and her children are to be protected.

The crisis is compounded by the woeful lack of resources needed to provide preventive intervention, care, and treatment for substance-abusing pregnant women, their newborns, and for other children in their families in danger of abuse and neglect. Florida's alcohol and drug treatment programs face limited resources and severe overcrowding, causing the specialized needs of women, especially pregnant women, to largely go unmet. The cocaine/crack problems, the AIDS epidemic, and new populations--such as addicted infants--in need of specialized services, are greatly expanding the scope of needed education, prevention, intervention, and treatment programs.

Recommendations

The nation needs a comprehensive approach to the problem of substance-exposed and addicted newborns at the federal, state, and local levels. We must focus on substance abuse treatment because it is critically needed, and on substance abuse prevention as well, which is ultimately less costly and more beneficial to society. An adequate response to the problem of drug-involved mothers and babies must address four major needs: (1) a system of early identification of at-risk women; (2) a system to increase prenatal care; (3) a system of treatment and rehabilitation services for high-risk women; and (4) a system of consistent policies and procedures concerning all aspects of working with the target population.

You in Congress have recognized the problem and acted to help. Both the Anti-Drug Abuse Act of 1988 (P.L. 100-690) and the Abandoned Infants Assistance Act of 1988 contain measures to assist the victims of maternal drug abuse. With money authorized under the Anti-Drug Act, the Office of Substance Abuse Prevention (OSAP) and the Office of Maternal and Child Health have jointly funded model projects for pregnant women who abuse drugs. The requests for proposals encouraged coordination and integration with existing programs. This encouraged communities to look comprehensively at existing services, and to examine ways to fill the gaps in prenatal care, prenatal substance abuse treatment, and post-delivery services.

Available funding has been far outstripped by the number of communities needing and requesting funds. Unfortunately, by the time model programs show results, many lives will have been greatly damaged. I encourage you to continue your foresight by increasing the funds available through the OSAP grants for services to women who have abused substances during pregnancy and their children. I urge you even more strongly to increase the Alcohol, Drug Abuse, and Mental Health Block Grant to provide treatment for these people. These programs should include residential treatment placements for mother and infant together, and should offer day care for the infant when needed and education for the mother in parenting skills.

Increased funding should also be made available to support state programs for at-risk and high-risk women; preferably through community-based substance abuse prevention and intervention services. Early intervention programs can:

- o identify women whose lifestyles or family/spouse substance abuse history place them at risk for substance abuse;
- o provide for an assessment that can target the full range of social, health care, and treatment needs for high-risk women;
- o identify pregnant women who may give birth to an addicted or drug-exposed newborn;

- o identify substance-abusing women whose children are at risk for abuse, neglect, and other problems; and
- o promote coordination and cooperation among health and social welfare agencies and community substance abuse treatment providers.

Coordination and cooperation is vital to insure that all perspectives are included in the policy development process and to avoid wasted effort and funds. All activities in Florida are part of an integrated service delivery system under HRS, which is linked together at the local level. There are many specific examples of our approach.

We have given community-based substance abuse treatment agencies funding to help public health nurses and child protective service workers identify women at risk and refer them to treatment. Cross-training has been developed to give provide them with a basic understanding of substance abuse, addition, and rudimentary treatment services and to acquaint community providers with the rules, regulations, and policies that public health and protective service workers operate under when dealing with cocaine babies. In addition, neonatologists from across the state have been involved in training and policy and program development as a way to link hospitals into the service system.

Treatment and rehabilitation services for women are one

of the most important approaches to prevent the birth of addicted or substance-exposed infants. The following services need to be available nationally to address the special treatment needs of women:

Prenatal care. The importance of funding prenatal care is recognized by both Congress and the states. Florida has seen an increase in full-term deliveries and a reduction in low-birthweight babies in women who enter drug abuse treatment after being identified by the HRS county public health units as substance abusers.

As programs are developed, staff can be trained to recognize the substance abuser. As I have said, health care providers today are often unable to diagnose substance abuse in pregnant women. To address this problem, I recommend increased funding in the Maternal and Child Health Block Grant for targeted health services for cocaine-abusing mothers and pregnant women. I also advocate teleconferencing, continuing education programs for health — care professionals, and including special courses on substance abuse in obstetrics in medical school curricula.

Substance Abuse Medical Consultation Services. Funds should be targeted for the Alcohol, Drug Abuse, and Mental Health Block Grant to provide screening and risk assessment capability through community-based treatment programs for public health providers. Comprehensive substance abuse programs need to be able to expand their medical staff with expertise in the medical management of alcohol and drug

abuse clients. These nurses and physicians can provide general medical and prenatal care for substance-abusing women.

Substance Abuse Treatment. Treatment programs must be funded to address a full continuum of care for women's services, including outpatient, day treatment, and residential. All of these services need to provide child care for women who cannot participate in treatment without this support.

Many female substance abusers do not have strong support systems, are unemployed or underemployed, and have long histories of substance abuse that create so much dysfunction that they are unable to care for themselves or their families. These women need therapeutically appropriate treatment that can:

- o limit the woman's access to alcohol or drugs;
- o help the woman avoid prostitution and criminal activities;
- o provide supervised access to medical and health care services;
- o provide remedial education or job training to foster personal and economic independence; and
- o provide intensive in-home family preservation services for the rest of the family.

Programs for Pregnant Women with Child Care Services.

To meet the special needs of substance-abusing women who are pregnant, treatment programs are needed that can provide child care and development services for young children often raised in drug-taking environments. Because many pregnant women have other small children at home, it is essential to have child care and development services available to enable the mother to enter treatment and to teach child care and parenting skills.

It is also important that women not be separated from their children soon after birth unless absolutely necessary. Treatment programs that allow the mother and infant to stay together will strengthen bonding and reduce the impact on the child welfare system now and for the rest of the child's life. Since adults who were nurtured as infants are more likely to nurture their own children, this investment has a long-term benefit financially and in the quality of life enjoyed.

As crack/cocaine use continues to spread; as females, especially minority women, are identified as greatly at risk to contract or spread AIDS; and as women using cocaine give birth to infants with severe complications, it is apparent that the lack of adequate women's substance abuse treatment programs exacts a devastating cost in economic and social terms. We must understand that substance abuse intervention and treatment provided to pregnant women who abuse alcohol or drugs can have a significant positive impact on the problem of drug-exposed newborns.

Clearly, the high rate of newborns exposed to cocaine can be reduced through substance abuse treatment that can produce a substance-free mother, a safe delivery, and a healthy baby. Treatment for substance abusing pregnant women has the potential to reduce cocaine-exposed births and also reduce the spread of AIDS. Florida ranks first in the nation in cases of pediatric AIDS. Pediatric AIDS is largely linked to a parent, often the mother, who has a history of intravenous drug use and/or prostitution. Substance abuse treatment costs much less than the estimated \$2,000 per day spent on treating the addicted infant or the estimated \$50,000 annually spent on an alcohol-related developmentally disabled baby; it makes good economic sense to support treatment for pregnant women and their children.

Other Approaches

A number of other approaches that complement comprehensive treatment efforts can help loosen the grip drugs have on the lives of our children. For example, primary prevention programs in our schools have a proven record of success: drug abuse prevention education works. According to the Institute for Social Research of the University of Michigan, drug use among high school seniors declined between 1987 and 1988. Funds should be provided for efforts such as the "Dare to be Drug Free" education programs, which follow the "Scared Straight" model program.

I also recommend adequately funding school health programs. Students using drugs or nearing the decision to

use them often come to the school nurse's attention before school counselors as they present specific or unspecified problems. Such funding should support an assessment of students for high-risk factors such as a parent with a history of substance abuse. This could be linked with other prevention programs, including suicide prevention. Individual, group, and peer counseling sessions should be provided to students targeted as high risk.

The media can also be used as a vehicle for information on drug abuse. Funding for public radio and television stations could be earmarked for programs on parenting, stress reduction, and drug education, including topics such as how to recognize drug use, how to avoid being an enabler, and what to do. Videos and tapes of these shows could be made available cheaply through video stores. Interactive videos on these subject could even be placed in arcades and shopping malls.

A range of other efforts would also help. Community youth programs providing youth activities and/or summer employment should be funded. Training should be increased for entry-level drug abuse workers, and strong drug abuse education programs should be incorporated into all corrections and health and rehabilitation programs. Law enforcement officials should be stationed in communities and housing projects known for drug-pushing, and community groups aimed at reducing the encroachment of drugs into their neighborhoods should also be encouraged.

A system of state hotlines for pregnant women with substance abuse problems, their families, and their friends should also be developed. We have one already in Florida-- 1-800-457-BABY. These hotlines would provide referrals and counseling to help the caller to use the referral. Operating the hotlines at the state level will allow them to better keep up with changes in referral agencies. A national hotline should be available for state hotline workers to turn to with particularly difficult questions or problems. We support current congressional and state initiatives to fund maternal and child health hotlines.

Mr. Chairman, I would like to conclude my remarks by saying that we in the human services see the tragic results of substance abuse every day. Drug abuse is a problem that cuts across social, economic, and demographic boundaries. We are committed to helping those who are caught in the grip of this grim plague, and most particularly the infants and young children who are its most innocent victims. Thank you.

Testimony of Howard Fuller, Ph.D., Director
Milwaukee County Department of Health & Human Services
to the
U.S. Senate Committee on Governmental Affairs
July 31, 1989

Thank you, Senator Glenn and your colleagues on this committee -- and particularly I want to thank the senator from my home state, Senator Kohl -- for the opportunity to testify on what I believe has rapidly become one of the most serious threats to this nation's urban communities, and to our children -- drugs, and in particular, cocaine.

I have been director of Milwaukee County's Department of Health & Human Services for just over one year. While I did serve in former Governor Earl's cabinet for the State of Wisconsin and have held administrative positions within higher education, my life really has been one of social activism. In particular, I have been an advocate for the needs of poor African-American youth and their families.

Therefore, given my background, I was shocked to learn, soon after taking this job, of the staggering volume and severity of child abuse and neglect referrals our Department of Social Services was receiving, and verifying, every day. In the past 5½ years, abuse and neglect referrals have more than tripled in Milwaukee County, and we expect the total in 1989 to be at least 20% higher than last year's record number.

Our child protection workers, the police, the district attorney's office and our Children's Court judges tell us that this startling increase in the abuse and neglect of children can be attributed to one factor, and one factor alone -- drugs. In Milwaukee, more often than not, the drug is cocaine. This drug is dominating the lives of its users completely -- to the total disregard of their children.

Let me give you a few examples of what drugs are doing to our families:

* Police went to a home where a neighbor had reported a "child abuse in progress." What they found was a home infested with cockroaches and strewn with broken glass, overturned furniture, rotting food, used syringes and razor blades. A 25-year-old woman, the mother of three children, including an infant, was passed out on a soiled bed. Her children had not eaten in two days, prompting her 7-year-old son to go for food to the neighbor who had called police. The children's grandmother said her daughter was a chronic cocaine user who sold her food stamps to buy drugs.

* A child protection worker, responding to an anonymous tip, went to a home she said she could smell from the street. Inside, living in filth, were eight children, ranging in age from 2 to 17, belonging to two sisters. Dirty dishes were on the floor. There was no running water and no food. The toilet and tub were caked with excrement. On the stove was a pot which had bubbled over and caught fire. Needles and bloodstained cottonballs were present and both women were on drugs, unable even to put out the fire.

* Acting at the request of a child protection worker, police raided a "shooter house" where users purchased and took drugs. In the basement was a pile of hypodermic needles a foot high and 1½ feet in diameter. Living in the house were 14 people -- three sisters and their 11 children, ranging in age from 1 to 17. Feces and garbage covered the floor, tub and toilet.

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The home had no furniture except a mattress with metal springs protruding. It had no heat, electricity or working plumbing. There was no food or eating utensils. The only adult there at the time was on drugs and too incoherent to answer questions.

That cocaine would lead to infants and young children being forced to live in such squalid, depraved conditions shocks the conscience. But the problem does not end there. Increasingly, we are also getting reports of infants born with cocaine in their systems, an indication that the mother used the drug within a few days of delivery and was, in all probability, a user during her pregnancy.

Until recently, our child protection staff received reports from time to time of infants born to drug abusing mothers with cocaine in their tiny bodies. However, Milwaukee County began to see a trend last fall when the number of reports from hospitals rose significantly. We began in January to keep track of these referrals. For a community the size of Milwaukee, the numbers are alarming. Through June, our Department of Social Services has received 134 reports of "cocaine babies" born in local hospitals.

These referrals are for situations where hospital staff fear the infant may be harmed if allowed to go home with the mother. However, the number of babies at risk because their mothers are addicted to cocaine is much larger than that. Hospitals in Milwaukee County estimate that, combined, cocaine is involved in 10% to 15% of all deliveries. Since they have from 12,000 to 15,000 deliveries a year, that translates to between 1,200 and 2,200 "cocaine babies" born in Milwaukee County each year.

This problem has become almost epidemic in our central city, where poverty caused by joblessness contributes to drug use. At one downtown hospital, 35% of the babies delivered during a one week period earlier this year tested positive for cocaine. Officials at this hospital say an average of 15 babies a month are born with cocaine in their systems. A second hospital serving inner city patients says it delivers an average of one "cocaine baby" a day.

Some inner city women apparently start using cocaine during pregnancy. In Milwaukee, the word on the street is that cocaine will get rid of an unwanted pregnancy. Because cocaine can rupture the placenta and lead to miscarriages, this bit of street wisdom can unfortunately prove to be true.

Whatever their motivation, there apparently is no limit to the desperate lengths these women will go to satisfy their craving once they are hooked. At one hospital, a nurse walked into the room of an expectant mother awaiting delivery and found her snorting cocaine. At another hospital, one newborn actually had a packet of cocaine on top of its little head as it came down the birth canal. The mother, in removing her clothing while awaiting delivery, had hidden the packet in her vagina.

I am sure you will hear testimony from others about the medical effects of cocaine on the newborn, so I will not comment on that subject except to note that studies show cocaine may cause brain damage, seizures, tremors, retarded growth, malformations, lowered birthweight and premature birth.

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The medical problems and potential disabilities of these infant victims of cocaine will add an incredible burden to our service system. They will require extensive medical care, which, if they are even fortunate enough to get it, will most likely be publicly funded. They, and their families, will need supportive services at a time when we cannot even meet the needs of the frail elderly, mentally ill and developmentally disabled persons who now are on our waiting lists. They will need special education programs when schools already are having difficulty achieving the educational goals for children who are not impaired. As I noted earlier, it is already having an impact on child abuse and neglect. Milwaukee County's health care and human service systems are at the breaking point. We must find a way to deal with this crisis!!

In my opinion, social problems, while they may be national in scope, are best dealt with at the local level. Accordingly, we are attempting to marshal what resources now exist to make a major assault on the problem of cocaine babies and their addicted mothers. Earlier this year, Milwaukee County established a cocaine and motherhood task force to study the issue, inventory existing services to this population, and make recommendations on what Milwaukee County government and the broader community can do to effectively address this problem.

This task force is made up of state, county and City of Milwaukee representatives. Numerous private social service, advocacy and substance-abuse treatment agencies are also represented. A special effort was made to involve African-American and Hispanic agencies. These two minority groups are significantly represented in Milwaukee's population, and also are the groups most seriously affected by this problem. On a related track, a committee of health care providers and health maintenance organizations are also looking at this problem, assisted by members of my staff, and will be working closely with the task force in developing recommendations. These two groups are also collaborating on a federal grant proposal to develop and provide prevention and treatment services to pregnant women and post-birth mothers involved with drugs.

This collaborative effort, we have found, is a significant breakthrough in dealing with this problem. A major obstacle to effectively serving this population is that cocaine-abusing mothers and pregnant women now interact with three separate service systems, all of which deal only with a segment of the total problem, and none of which are now accustomed to collaborating with each other. The health care system deals primarily with the prenatal and post-delivery medical needs of the mother and infant. Drug treatment professionals are involved solely with the addiction, often with little thought as to how a mother in treatment can continue to care for her children. Child protection workers are charged with monitoring the physical safety of the child. As a result, child protection staff, drug counselors and therapists, and physicians and public health nurses often work in isolation, not as a team. The three systems are working apart when they really need to be working together.

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To encourage such a coordinated effort, my department is proposing a \$409,000 "cocaine baby project" for 1990. If approved by our County Executive and County Board, the project would call for child protection staff to work intensively with pregnant women and families with newborns identified by hospitals, physicians and public health clinics and nurses. An advocacy team would seek to obtain drug treatment for the mother, with funds allocated to help pay for treatment. Our goal is relatively simple: get prenatal and postpartum care for the mother and child, deal with the mother's addiction, and coach the mother in parenting and caregiving skills to reduce the chances of abuse or neglect.

What can the federal government do to assist Milwaukee County and other communities in combating this problem? Two things:

First, funding is desperately needed to support the full array of services which are needed for this population, including residential treatment programs where children can stay with their mothers. Much of the federal drug abuse rhetoric, as well most of the dollars, are targeted toward law enforcement. Too few dollars trickle down to treatment programs. As a result, there are few opportunities to offer pregnant women or post-birth mothers the intensive treatment and support needed to beat their addiction. Treatment is expensive, and it is easy to understand why the public's mood, and that of elected officials, would be to spend money to punish drug users and their suppliers, and not on treatment. But society cannot afford to ignore these most innocent of all victims, the children of drug abusing parents.

Second, more coordination is needed at the federal level. Recently, our department has received notice of seven federal grant opportunities, some targeted at different substance-abuser groups, including intravenous drug users, youth gangs, homeless or runaway children, youth which are considered to be high risk, and pregnant and post-birth mothers. Some grants are for treatment or prevention, others for prevention only. Each grant, by itself, addresses an important dimension of the drug problem. Unfortunately, the seven grants are being disbursed by six separate federal agencies. Who's in charge here? I realize William Bennett has been given that responsibility, and that it is still early in his administration. It is important, however, that the federal government achieve the same degree of coordination it demands from state and local governments.

It is also important that the federal government, in disbursing funds, give local jurisdictions flexibility to address local needs. I am not talking about accountability, with which I have no quarrel. However, it is important for you to keep in mind that our elected officials charge us with establishing priorities and making tough decisions. As our cocaine and motherhood task force illustrates, we are helped in these decisions by a community participation and advisory process. I believe the community should make the decision as to where whatever limited resources are available can best be used.

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Drug abuse has become one of our country's top domestic priorities. The Congress and the President are attempting to attack this problem from all angles. The emphasis on law enforcement is understandable, and very important. But we cannot ignore treatment, which has to be directed at the drug abusers. It is not possible to help the innocent victims of this scourge -- the children -- without helping their parents.

I urge you to consider not just the present reality but the future of our country as you grapple with what too many must seem to be an intractable problem. We must ask the question: What will our nation be like when these physically, emotionally and developmentally damaged children become adults? I am sure you will agree, money spent now on treatment, prevention and early intervention will save millions of dollars in future years in law enforcement, health care and supportive care.

Thank you again for the opportunity to address you. I would be pleased to attempt to answer your questions.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Assistant Secretary
Washington DC 20201

Statement
by
Mary Sheila Gall
Assistant Secretary for
Human Development Services

Before
Committee on Governmental Affairs

U.S. Senate
July 31, 1989

Mr. Chairman and Members of the Committee:

I am pleased to appear before you today to discuss the activities of the Office of Human Development Services (OHDS) related to drug prevention, intervention and treatment services for women, infants and children.

The drug abuse crisis in the U.S. is serious and growing. As Assistant Secretary for Human Development Services, I am responsible for administering a wide variety of social service programs which serve some of the most vulnerable members of American society. The severity of the drug abuse problem is having a devastating effect on America's families. I am most concerned about the impact that drugs are having on many of the populations we serve. There is a compelling need to increase coordination of drug abuse prevention and treatment with social services for our affected families at the Federal, State and local levels. While we have begun this coordination - much more remains to be done. In my testimony I will discuss how these drug problems are impacting families and affecting some of the programs administered by OHDS. I will also describe some of our activities to address these problems.

Runaway and Homeless Youth

The Runaway and Homeless Youth Program through its network of over 300 shelters has been involved with the problems of drug abuse prevention, reduction and treatment for many years. Reports from the centers for runaway and homeless youth indicate the growing problem of drug abuse. In 1988, 16.6% of youth entering the centers reported their reason for running as drug and/or alcohol abuse on the part of their parents. In addition, 15.4% of youth entering the centers indicate a personal drug abuse problem. The prevalence of the problem is underscored by the fact that not only are major urban areas reporting an increase in drug use among their runaway clients, but also that providers in small towns and rural communities are finding that up to 67% of their clients are reporting drug abuse as a primary problem. The street life environment of runaway and homeless youth places them at risk for involvement in the abuse of illicit drugs and the related consequences of contracting and transmitting the AIDS virus through contaminated needles or sexual contact. There is no doubt that youth entering the basic centers today are more disturbed and more difficult to deal with than in the past, particularly due to the increase in substance abuse.

The Anti-Drug Abuse Act of 1988 established a new \$15 million program to reduce and prevent the illicit use of drugs by runaway and homeless youth. Over 160 public and private agencies have submitted applications under this new program. We expect that all funding decisions will be made by late September 1989. In implementing this program, OHDS worked closely with staff from the Office for Substance Abuse Prevention as well as other Federal programs.

Another example of OHDS' coordination with other agencies include a Memorandum of Agreement between OHDS' Family and Youth Services Bureau and the Bureau of Health Care Delivery and Assistance in the Health Resources and Services Administration to provide health care, disease prevention, and drug treatment services to youth in the Runaway and Homeless Youth Centers. Agreement has also been reached with the National Institute on Drug Abuse (NIDA) to obtain training for staff of runaway centers in the NIDA developed AIDS Prevention Training Curriculum in fiscal year 1990. In addition, regular meetings are being held with staff of the Office of Substance Abuse Prevention for the purpose of planning future joint activities.

Another new program established by the Anti-Drug Abuse Act is the Drug Education and Prevention Program Relating to Youth Gangs. The target population for this new \$15 million program are youth at risk of involvement with gangs which commit drug related crimes. The prevalence of gangs and associated illicit drug-related activity is widespread. A study underway at the University of Chicago estimates that 300 cities are experiencing problems with youth gangs. While smaller cities and suburban areas are experiencing an increase in youth gang activities, the strongest presence is in major population centers. Associated with the recent increase in youth gang formation is the apparent increase in youth gang violence and deaths due to the use and sale of drugs.

We have worked closely with the Office of Juvenile Justice and Delinquency Prevention in the Department of Justice, the Office for Substance Abuse Prevention, and the National Institute on Drug Abuse in developing the request for grant applications under the program. Over 250 public and private organizations have submitted applications for grants under the youth gang program. We will make funding decisions by the end of September.

Head Start

Head Start is a comprehensive child development program which serves approximately 450,000 children and 420,000 families. Head Start has long recognized the primary role the family plays in a child's development. A keystone of Head Start's success has been its social service and parent involvement component. Head Start families are typically very needy in terms of income, (51% of children live in households with income less than \$6,000) employment, (47% of heads of households are unemployed), and education (49% of heads of households have less than a high school education).

The growing problem of substance abuse has been identified by many of Head Start's 1,900 local programs as a factor which demands our attention and action. A recently completed study by the HHS Office of the Inspector General determined that substance abuse was reported as one of the most common problems of dysfunctional families served by Head Start programs in both rural and urban areas. Substance abuse (along with child abuse and neglect) was the problem cited most often as having worsened over the past two years.

Head Start staff estimate that at least 20% of children in Head Start have a parent or guardian who has substance abuse problems. Furthermore the problem of substance abuse in Head Start families is increasing.

Head Start Program Directors, social service providers, and teachers describe the negative impacts of substance abuse they have witnessed. The problems include:

- o Increased family instability which reduces meaningful parent participation in the program, disrupts the child's attendance in the program, and creates an environment for the child which is often chaotic and frightening.
- o Teachers and family service providers report increased stress and frustration in dealing with families involved in substance abuse.
- o Neighborhoods in which some Head Start programs are located and their families live, are so disrupted by drug-related crime that families and staff report a pervasive sense of fear.

- o Increased involvement of Head Start Family members in criminal drug-related activities leads to family violence, incarceration of parents, and increased incidence of children being placed in foster-care or with extended family members.

To address the problem of substance abuse, Head Start is doing the following:

- o Head Start Bureau staff met in June of 1989 with representatives of the Office for Substance Abuse Prevention (OSAP) to plan collaborative efforts to ensure that our grantees will have access to the most current information and resources addressing substance abuse. A representative of OSAP will address the 1,000 Head Start staff expected to attend the Social Services Institute in Washington, D.C. to be held August 7-9.
- o The Head Start Bureau is convening a national meeting on August 9th & 10th in Washington, D.C. to develop an action plan for Head Start grantees to address substance abuse. Persons attending the meeting will include Head Start grantees who are demonstrating model programs for substance abuse prevention, Head Start Program Directors and staff who have expressed special interest in confronting these problems, and consultants from Federal agencies and Universities.

- o As a result of this meeting, we expect to determine what information and resources our grantees need most to address substance abuse issues, and how we can ensure that grantees connect with information and services resources which can help them be a partner in prevention of substance abuse.
- o The National Head Start Association is developing a curriculum for prevention of substance abuse geared to young children and families in Head Start. The project, funded by a grant from OSAP will be completed in October 1989 and reviewed for possible national dissemination.
- o Head Start has awarded several grants to address substance abuse. For example, a Head Start program in Dallas, Texas, in collaboration with Texas Tech University is field testing a drug abuse prevention program for Head Start parents. A videotape series and staff training manual are being developed. Preliminary reports indicate the series is helpful in raising staff and parent awareness of substance abuse and in promoting effective referrals of parent to substance abuse treatment programs. This grantee will be describing their project at the August 7 meeting of the Head Start Social Service Institute.

Child Welfare

In recent years, the intensity of problems experienced by families served by public and private child welfare agencies has increased considerably. For example, an increasing number of children entering the child welfare system do so because of child abuse and neglect related to substance abuse. Particularly troubling are the growing numbers of drug dependent babies needing placement and the number of children with HIV positive infections or AIDS.

Increasingly, more and more infants are being born to chemically-dependent mothers. A recent nationwide hospital survey conducted by the National Association for Perinatal Addiction Research and Education found that the annual number of newborns who are drug-damaged is estimated to be 375,000. Infants born drug-exposed have increased three-to fourfold since 1985 and it is estimated that approximately 10% of women use drugs during pregnancy. According to a 50 State telephone survey conducted by the National Committee for Prevention of Child Abuse, substance abuse was the dominant characteristic in the child abuse and neglect caseloads of 22 states and the District of Columbia. Almost 90% of the caretakers reported for child abuse in these states are active substance abusers.

Drug-exposed babies are more likely to be born prematurely, have low birthweight, exhibit developmental delays along with motor, speech and emotional impairments. These babies also suffer disorders to the central nervous system characterized by hyperirritability; gastro-intestinal dysfunction; and respiratory distress. These infants are very difficult to care for and are unable to bond with their caretakers.

These factors are compounded by the mother's inability to act as a parent and places these infants at a high risk of maltreatment. These mothers themselves come from disorganized, disrupted and sometime violent backgrounds and suffer high rates of depression, a sense of worthlessness and social isolation. Studies have shown that these mothers are more likely to abandon their infants in the first year of life; have another child in out-of-home placement; have no permanent residence and refuse to participate in treatment programs. Substance abusing parents are significantly less likely to make progress in treatment either in terms of improving their own functioning or improving their parenting skills.

Furthermore, only a small percentage of drug-abusing women have access to treatment. Resources are very limited; there is an acute shortage of treatment facilities for substance-abusing pregnant women who seek help. Often, pregnant women are not

accepted in drug treatment programs. There are virtually no services to rehabilitate drug-addicted mothers and children after birth. Even the few available treatment programs have difficulty retaining these women. But even with treatment many professionals question the ability of chronic drug abusers to adequately care for their children. Many Child Protective Service workers question the wisdom of discharging chemically-dependent babies directly home with parents without some treatment intervention and monitored parental interaction. Others believe that the home environment of drug-born babies should automatically be investigated to determine if the child's home environment is safe and that parental drug abuse alone should justify court intervention.

The Children's Bureau has undertaken several projects in the last two years to improve the capacity of States and child welfare agencies to provide care for these children.

- o In fiscal year 1987, we funded four, three-year demonstration projects designed to reduce the risk of neglect and abuse in infants born to chemically-dependent mothers. These projects provide parenting skills training and support groups; vocational counseling; drug/alcohol rehabilitation

and social and psychological support. The expected outcomes are a reduction in the risk of abuse and neglect; out-of-home placement; incidence of failure to thrive; injuries and preventable hospitalizations; and improvement in mother/infant interaction; maternal parenting skills and enhances growth and development of the infant.

- o In fiscal year 1988 the Administration for Children, Youth and Families (ACYF) and the Administration for Native Americans (ANA) funded five projects with Indian Tribal social service agencies to work with families in alcohol abuse prevention/intervention.
- o In fiscal year 1988 ACYF funded four projects as part of the overall Departmental effort of addressing pediatric AIDS. Much of what we will learn in the development and assessment of service delivery models in this area will also apply to infants affected by the alcohol and drug abuse of their mothers during pregnancy.
- o Also in fiscal year 1988 we funded 16 crisis nursery projects under the Temporary Child Care For Handicapped Children and Crisis Nurseries Act. While these projects are programmatically linked to infants involved with abuse and neglect, the knowledge and experience gained in this area should also contribute

to care and service delivery issues concerning infants affected by substance abuse. In fiscal year 1989 we will fund 18 more projects in this area. Four of the fiscal year 1988 projects are focusing specifically on drug addicted babies.

- o We have continued to fund the National Resource Center for Family Based Services. State social service and state mental health programs are developing and adapting models of intensive family based services to prevent children from dysfunction families from being placed in foster care. The Resource Center provides information through its clearinghouse. It also provides consultation, needs assessments, and extensive training. Family based treatment programs are increasingly dealing with substance abuse families. We have an extensive evaluation study of this technology under way by the University of Iowa.

In conclusion, I want to assure you that OHDS will continue to work with State and local agencies and other Federal agencies to improve coordination of services to address the problems caused by substance abuse.

I will be happy to answer any questions you may have.

For Release Only Upon Delivery

STATEMENT

BY

ELAINE M. JOHNSON, PH.D.

DIRECTOR

OFFICE FOR SUBSTANCE ABUSE PREVENTION

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
PUBLIC HEALTH SERVICE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS

July 31, 1989

Mr. Chairman and Members of the Committee, I am Dr. Elaine M. Johnson, Director of the Office for Substance Abuse Prevention (OSAP) of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). I am grateful for the opportunity to testify at this hearing on the scope and nature of illicit drug use among pregnant women in this country.

Nature and Scope of the Problem

The crisis of drug abuse in our country is producing a catastrophe for our most vulnerable and innocent citizens: babies born to substance-abusing mothers. Our most conservative estimates of the number of these most innocent victims are staggering -- one of approximately 10 babies born in America today suffers the consequences that stem from their mother's use of illicit drugs during pregnancy (Chasnoff, 1988). These figures do not take into consideration the widespread use of alcohol by pregnant women, which would dramatically increase the number of infants affected by substance abuse.

We estimate today that more than 1,200 babies will be born who have been exposed to illicit drugs in utero. If they live (babies of substance-abusing mothers have a very high mortality rate), these babies are likely to have severe and persistent physical and/or neurological damage. At a minimum, these 375,000 affected babies born each year will place extraordinary demands on their families, the health care community, the educational system, the criminal justice system, and the general public.

Each year the drug epidemic continues. The size of the problem is compounded by the addition of new damaged babies to those already born and suffering.

The estimate of affected infants probably understate the true extent of the epidemic. Many of these women are not in the health care system and are not being identified. Their infants may appear normal at birth, but experience drug withdrawal symptoms days or weeks after leaving the hospital and developmental delays that persist into childhood and beyond. Unless this population of women and their infants becomes linked to the health care system, the tendency is for substance-abusing mothers to be invisible to studies assessing the magnitude of the problem.

There is also underreporting of the incidence of substance abuse for those women seen in medical settings during pregnancy. The greater the intensity of screening, and the greater the rigor of documenting substance abuse in medical records, the higher the percentage of pregnant women found to be using these substances. A 1989 survey conducted by the Select Committee on Children, Youth and Families found 13 of 18 hospitals reporting 3 to 4 times as many drug-exposed births in 1989 as in 1985. We are experiencing a crisis that is accelerating, with more babies exposed to more drugs and more powerful drugs each year that the epidemic persists.

Finally, Human Immunodeficiency Virus (HIV) infection in young children is inextricably linked to drug use in adults. Of

all HIV-infected children under 13 years of age in the United States, about 80% have a parent who is HIV positive, many of whom are addicted. Evidence suggests that up to 50 percent of infants born to HIV infected mothers are infected themselves (Falloon, Eddy, Wiener and Pizzo, 1989).

Service-Delivery Issues

From a public health policy perspective, one of the most striking findings to emerge from this epidemic of drug abused babies is the inadequacy of our current approaches to service delivery. Women abusing substances during pregnancy have multiple needs, including the need for alcohol and drug abuse treatment, other health care needs, and a variety of psychosocial needs. They often face simultaneous stresses of poverty, addiction, and new motherhood with inadequate support and social resources.

Service delivery systems are often uncoordinated and/or inadequate. For example, many substance abuse treatment programs refuse to serve pregnant women. Many maternal health care facilities are inadequately prepared for the problems of substance-abusing women. Women unwilling to present themselves for services or treatment are often difficult to locate, and furthermore, after they are recruited for treatment, their program attrition rates are usually high.

The crisis of drug-exposed babies points to the foremost issue for drug-using or drug-addicted pregnant women -- they get no treatment whatever. Most drug-using pregnant women receive

neither prenatal care nor drug treatment services. Women who do seek help during pregnancy have a difficult time finding it. According to the 1989 Select Committee survey, two-thirds of the hospitals queried reported that they had no place to refer substance-abusing pregnant women for treatment. While I personally know of several comprehensive programs for pregnant women that offer both drug treatment and prenatal care, I also know that these types of programs are very rare.

The problem of inadequate and uncoordinated service systems affects other groups in addition to the medical and the drug treatment systems. For family court judges, for instance, the problem faces them daily. In Miami, 37 percent of all child and neglect cases filed between March and June this year in the juvenile division of the Dade County Circuit Court involved babies born with cocaine-related problems. I would like to quote from Dade County Circuit Judge William E. Gladstone at last week's annual conference of the National Council of Juvenile and Family Court Judges, "If you add to those the parents who were allegedly abusing and neglecting their children because of cocaine, it's 60 percent of the cases filed through June." Like most of the judges at the conference, Judge Romae Powell, president of the Council, indicated that he feels powerless to find a solution.

The above issues are important, pressing, practical problems. . They expose public policy issues that must be handled at local, State, and Federal levels. Several policy issues are

critical:

- o When is the best time to intervene?
- o Who should have primary responsibility for intervening?
- o Who will pay for the intervention(s)?
- o How can the many parties responsible for addressing pieces of this problem be linked to produce effective solutions and services?

Federal Efforts Through the Office for Substance Abuse Prevention

The Office for Substance Abuse Prevention within the Alcohol, Drug Abuse, and Mental Health Administration has actively joined other Federal Government agencies in seeking effective approaches to resolving these policy issues. OSAP's approach has been collaborative, working with and building coalitions and sponsoring innovative models at local, State, and Federal levels. Under the Anti-Drug Abuse Acts of 1986 and 1988 (P.L.99-570 and P.L.100-690), OSAP has worked to develop a variety of collaborative efforts to address the many problems of drug-addicted babies, and join with the many agencies and organizations involved in issues of substance-using pregnant and postpartum women and their infants. The next portions of my remarks briefly describes OSAP's activities and collaborations at the local community, national, and Federal levels to address this crisis.

Coordination of Local Services

At the local level, the challenge for the field is to design programs that can be preventive in focus and comprehensive in

design, involving prenatal care, drug treatment, and infant-parent support. Projects must forge linkages that bring together therapeutic programs, comprehensive supportive services, and medical care in a readily accessible form. We have found that service providers must take a longitudinal perspective, considering the needs of women and their babies before, during, and after delivery. Extensive community outreach and retention efforts are required to eliminate existing barriers to treatment.

Several pioneering programs have developed linkage and coordination models for local care systems through grants awarded by OSAP in its High-Risk Youth Demonstration Grant program. Two examples are representative:

Operation PAR, Inc. in Pinnellas Park, Florida is a substance abuse prevention program that features an innovative multi-service program to break the destructive cycle of inter-generational addiction. This program employs a systems approach that combines aggressive case management and outreach to pregnant, substance abusing women with a variety of treatment and rehabilitation services. PAR's services for women and their infants are coordinated with the local health department, local hospital pediatrics departments, child protection teams, the local juvenile court, and drug treatment systems. In 1988 PAR opened a Child Development and Family Guidance Center, a residential treatment center for youth with alcohol and other drug problems. Project staff locate and counsel pregnant drug

abusers, provide day care for their children, counsel family members, and educate people in the community about the dangers of alcohol and other drug use by pregnant and postpartum women. Operation PAR receives referrals from local hospitals, medical centers, and private physicians.

The National Public Services Research Institute in Landover, Maryland, operates a hospital-based substance abuse prevention and early intervention program in conjunction with the Prince Georges County Department of Health. This OSAP-funded demonstration program aims at reducing the risk of alcohol and other drug use among pregnant teenagers, as well as the risks to their unborn children, siblings, and others associated with them. Trained professionals (primarily nurses) identify pregnant teenagers who use alcohol and/or other drugs, and intervene in order to reduce the danger to both parent and unborn child. Working closely with county maternal and health care service providers, project staff link pregnant teenagers to county educational, counseling, and treatment resources. The program also provides these services to substance-using teen parents. Children of these mothers, identified as suffering from neglect and abuse, are referred with their parents to appropriate community services. Project staff train health professionals to identify pregnant and parenting teenagers who have alcohol and other drug problems, provide these young women with referrals, and monitor their subsequent progress.

Building on our experience with these initial demonstration

programs, OSAP jointly funds a demonstration grant program with HRSA's Office of Maternal and Child Health (OMCH). The program focuses on model programs for pregnant and postpartum women and their infants. This joint effort allows the OMCH to provide expertise in the development of perinatal health components and OSAP to provide expertise in prevention/early intervention services with high risk substance abusing populations. A total of \$4.5 million is available to fund this initiative in fiscal year 1989. We anticipate funding approximately 20 grants. We have consistently found applicants developing means for crossing agency and service delivery system boundaries to link substance-using pregnant women to the broad array of services that they and their babies need. Innovative linkage and coordination strategies proposed by applicants include:

- o Use of indigenous community health workers who live in targeted public housing projects who can reach out to high-risk women, link them to services, follow-up to assure that they reach services, and trouble-shoot to reduce barriers (such as providing child care so a pregnant woman can attend drug treatment or perinatal care appointments).
- o Many applicants propose incentives to recruit or retain women in treatment. One proposes evening prenatal clinics, on-site child care, and a hot meal for pregnant women and their male partners as incentives for continued participation.
- o Programs have proposed ways to link high risk, hard-to-reach

pregnant women to the many services that they need. One proposes "one-stop shopping," where a pregnant teenager can receive a comprehensive array of treatment and prevention services in one setting without traveling to multiple sites. Others propose aggressive case management, often offering to accompany women to appointments, and following these women and their infants for months, sometimes years, after delivery to assure continuity of care. While these proposals are expensive, the cost of not providing the services would be much higher in the long run.

Generally, local programs have found that it is unrealistic to expect that any one agency can provide for the multiple needs of substance-abusing pregnant women. They see, as does OSAP, that this is a community problem, not a maternal and child care or a substance abuse problem, and there is a need for a multidisciplinary approach which involves the expertise of all types of health providers.

Immediately after the initial group of 20 to 25 demonstration grants are funded under the OSAP/OMCH announcement, OSAP will hold a national meeting to bring all grant recipients together with other leaders in the field to begin developing collaborative networks between service providers, researchers, and public policy officials. This "Learning Community" will be a laboratory for assessing the effectiveness of collaborative demonstration models and identifying successful strategies for overcoming barriers to providing services. Each demonstration

program is required to conduct careful process and outcome evaluations of its services. In addition, OSAP has established a national evaluation project that is already conducting cross-site evaluation studies of the high-risk youth demonstration grant program. This national evaluation project will be expanded to encompass the pregnancy and postpartum programs to be funded this summer.

At the local level, however, it is very difficult to resolve critically important issues:

- o Who will pay for care?
- o Who will handle medical liability responsibility for high-risk patients who are often noncompliant and resistant to traditional medical services?
- o How are the rights of fetuses, infants, and children of substance-abusing parents protected?
- o How can confidentiality rights be assured when multiple agencies and services are needed to address multiproblem substance abusing pregnant women?

Such issues are not easy, and call for state and Federal resolution. In addition, local communities often do not have access to the research sophistication and resources to answer questions concerning the relative effectiveness of interventions. Nor can they provide the training and materials necessary for local clinicians, judges, police, substance abuse counselors, and others to ensure the most effective care possible for substance abusing women and their children.

Coordination at the Federal Level

OSAP has joined with other Federal agencies, and with a large number of national associations, to address these issues. As a new agency with a broad mandate to develop and disseminate effective prevention and early intervention models for high risk youth and their families, OSAP has been able to develop collaborative interagency networks that model on the Federal level what local communities have had to create individually to address the crisis of substance abusing pregnant women and their infants.

Listed below are some of the collaborative working arrangements that OSAP has begun with other Federal agencies:

Department of Agriculture

OSAP has joined with DoA in an interagency agreement to plan and implement cooperative program activities related to the provision of services to pregnant and post-partum women and infants in the area of drug abuse prevention, education, and treatment, particularly the provision of drug abuse information and referrals to women participating in the Women, Infants, and Children (WIC) Program.

Office of Maternal and Child Health

As previously discussed, OSAP and the Office of Maternal and Child Health of Health Resources and Services Administration (HRSA) have entered into an interagency agreement to fund jointly the demonstration grant program to develop model programs for pregnant and postpartum women and their infants. OMCH has

TESTIMONY OF G. SCOTT DUNN
 ACTING ADMINISTRATOR, FOOD AND NUTRITION SERVICE
 U.S. DEPARTMENT OF AGRICULTURE
 BEFORE THE U.S. SENATE
 COMMITTEE ON GOVERNMENTAL AFFAIRS
 JULY 31, 1989

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on the implementation of provisions in the Anti-Drug Abuse Act of 1988 affecting the Special Supplemental Food Program for Women, Infants and Children (WIC).

I would like to begin by describing the WIC Program and its operation. WIC is a national program with the goal of preventing health problems and improving the health status of low-income pregnant, breastfeeding and postpartum women, infants and children up to five years of age, who are at nutritional risk. The WIC Program provides foods, nutrition education and health and social service referrals to its participants.

The foods provided by the WIC Program are high in protein, calcium, iron, and vitamins A and C, and are meant to supplement the diets of program participants. The nutrition education provided by WIC emphasizes the relationship between proper nutrition and good health. A minimum of two nutrition education contacts are required during each certification period. During these nutrition education contacts a wide range of topics are

covered to help participants improve their eating habits, improve their health status and provide information on breastfeeding. As an adjunct to health care, WIC refers participants to health care providers as well as other health and social services.

The WIC Program has long been concerned about the effect of substance abuse on program participants. The abuse of alcohol, tobacco and other drugs is included among the nutritional risk criteria used for enrolling pregnant, postpartum and breastfeeding women in WIC. In many States, warnings about the danger of the use of these substances during pregnancy are provided during nutrition education counseling. Since 1978, referrals to alcohol and drug abuse counseling have been required by program regulations.

On November 18, 1988, President Reagan signed into law the Anti-Drug Abuse Act of 1988 (P.L.100-690). This law requires that the WIC Program provide program participants with information on the dangers of drug abuse during pregnancy and referrals to drug abuse counseling and treatment. The law also directs the Department to conduct a study of appropriate methods for drug abuse education and to prepare drug abuse education materials for distribution to State agencies.

As a result of this legislation, the goal of WIC's drug abuse effort is to raise awareness about the dangers of drug abuse

especially during pregnancy and to provide referrals for drug abuse treatment among WIC's high risk population.

Some of the Department's efforts related to the WIC mandates of this legislation are:

- o A report is being prepared which will recommend effective methods for providing drug abuse information and referrals in the WIC Program based on current knowledge in the field of drug abuse prevention.
- o A resource manual is being developed to provide technical assistance to WIC professionals for enhancing local drug abuse information and referral efforts.
- o A review of existing drug abuse education materials is currently underway which will result in recommendations for the development of materials for WIC participants.
- o A regulation which will clarify WIC's responsibility to provide participants with information on the dangers of drug abuse and referrals to available substance abuse services is being prepared to formally codify the WIC mandates of the Anti-Drug Abuse Act of 1988.
- o Nominees for the two positions on the National Advisory

Council on Maternal, Infant and Fetal Nutrition designated for experts on drug and alcohol abuse education have been named and are in formal clearance.

- o Attention to the topic of drug use during pregnancy at WIC forums is being encouraged and supported. For example, in February 1989 we arranged for Dr. Ira Chasnoff, an expert in perinatal addiction, to discuss this topic at the annual meeting of the National Association of WIC Directors (NAWD). Currently, we are cosponsoring a grant application with NAWD to support the dedication of an entire day to the topic of substance abuse at the February 1990 meeting.

The Department has taken this legislation very seriously. At the onset, we identified and approached Federal agencies with drug abuse prevention expertise, or new or expanded responsibilities under the 1988 anti-drug legislation, to ensure the coordination of activities wherever possible. This coordination is intended to minimize duplication and maximize effectiveness of efforts to reduce the incidence of drug use during pregnancy. Our coordination efforts have included several activities:

- o We developed an Interagency Agreement which was signed this spring with the Department of Health and Human Services' Office for Substance Abuse Prevention (OSAP).

The agreement outlines specific areas for coordination including program information sharing and drug abuse information dissemination. Already, OSAP has provided technical assistance for selection of a contractor for the legislated study, and OSAP keeps us updated on new and relevant information about drug abuse prevention.

- o We are also developing a mission statement to identify responsibilities and areas for coordination among the Federal agencies and programs with drug abuse prevention responsibilities related to pregnant and breastfeeding women and their infants. In addition to OSAP, we have initiated contacts with the Maternal and Child Health Program, Department of Health and Human Services, and the Department of Education to solicit their support for this effort.
- o We have participated actively on the Substance Use and Pregnancy Subcommittee of the Healthy Mothers, Healthy Babies Coalition to facilitate our coordination efforts and increase our awareness of other efforts to prevent substance abuse among the maternal and infant populations.

In summary, we recognize the seriousness of the problem of drug abuse in our society today, including the tragic consequences of

prenatal drug use. We believe that the limited role identified for the WIC Program, that of providing drug abuse information and referrals, is appropriate. WIC supports efforts to reduce the incidence of prenatal drug use by raising awareness of the danger of use during pregnancy and facilitating referrals for treatment where such treatment is available; however, WIC must continue to concentrate on its primary mission of providing nutritious foods, nutrition education and health care referrals to improve the health status of women, infants and children during critical periods of growth and development.

Mr Chairman, that concludes my testimony. I will be pleased to answer any questions you or the Committee might have.

STATEMENT

C. PETER BROCK

DIRECTOR, ALCOHOLISM AND MENTAL HEALTH PROGRAMS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

Before the
Committee on Governmental Affairs
United States Senate
101st Congress, First Session

July 31, 1989

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Committee

Mr. Chairman, my name is Peter Brock. I am Director of Alcoholism and Mental Health Programs in the Office of the Assistant Secretary of Defense for Health Affairs. I appreciate the opportunity to testify today. The grave and pervasive problems of alcohol and drug use, misuse and dependence in our society today are present in our military men and women and their families as well. The Department of Defense has given high priority to addressing these concerns, as they affect both our active duty force and their dependents, and our civilian employees as well. We recognize the importance of the military family not only in terms of our obligations to them, but also in the role they play in the accession, retention and effectiveness of our uniformed personnel.

While the drug testing of our military personnel has been the most visible aspect of our alcohol and drug abuse prevention efforts, the Department of Defense has a wide spectrum of policies and programs aimed at the various populations for whom we have some responsibility. Because of the focus of these hearings, I will restrict my comments largely to those activities relating to women, infants, and children.

PREGNANT WOMEN AND INFANTS

In the nearly 100,000 live births in fixed military facilities worldwide in Fiscal Year 1988, we do not have evidence of a single neonate born in withdrawal due to drug or alcohol use by the mother. While we cannot rule out the presence of fetal alcohol or drug effects, there is a strong prenatal care program available to all pregnant women, both active duty and dependent spouses. Because there is no financial barrier to this care, it is our sense that virtually all pregnant beneficiaries avail themselves of it. Providers and health educators in the Services are encouraged to give a message to women who are pregnant, or at risk of becoming pregnant, that they should not use any drug without the knowledge and expressed consent of their doctor, nurse or other healthcare provider. This includes not only illegal drugs, but prescription medications, over-the-counter preparations, and particularly alcohol and tobacco. Those women who smoke and/or drink alcohol are urged to abstain during the term of their pregnancy and breast feeding. While it is only an inferential relationship, a 1986 Obstetrical Outcomes Study showed that DoD live births contained a significantly lower percentage of low birth weight babies compared to national statistics (3.84 percent of DoD births below 2500 grams, 6.53 percent nationally).

While we do not have readily available statistics, it is our sense that the prevalence of alcoholism and drug addiction is extremely low among pregnant military women and spouses. Any woman determined to be either abusing or dependent on alcohol or other drugs would be referred depending on her status. Active duty personnel would be referred to a military program. Civilian spouses would most likely be referred to a private program through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

We have little or no data on one population: unmarried adolescent dependents of military personnel. They would most likely receive care through CHAMPUS or through other private or public programs whose records are not available to us.

WOMEN

Women in the military are subject to the same educational and monitoring programs as their male counterparts. This means that they receive structured educational units about alcohol and other drugs at specified points in their military careers: induction, permanent change of station, assumption of a command, reenlistment, subsequent to an alcohol or drug related incident, etc. They are

also subject to urine testing for the presence of drugs, as well as breathalyzer or blood testing for alcohol at induction and subsequently if indicated by behavior.

Data collected in our 1988 Worldwide Survey of Substance Abuse and Health Behaviors Among Military Personnel indicate that active duty females tend to drink significantly less than their male counterparts and that a slightly lower percentage (8.4 versus 9.0) have used drugs in the prior twelve months. Individuals who are determined to be using any drug or to be using alcohol excessively or inappropriately are referred for an assessment. Based on the outcome of this assessment, a referral may be made to one of three levels of therapeutic intervention: awareness/education, nonresidential rehabilitation, or residential treatment. Any individual who is referred to one of the latter two programs is monitored for a minimum of a year as part of the required aftercare component of rehabilitation. The DoD Instruction on Rehabilitation and Referral Services for Alcohol and Drug Abusers (DODI 1010.6 dated March 13, 1985) states that initial patient assessment must include family data. Further, an initial plan for family involvement in rehabilitation is included whether or not the family member(s) or other significant person(s) attends. When existent, the co-dependent's illness is to be viewed as a separate condition,

and - within the limitations of existing regulations - the family member is given a high priority in receiving rehabilitation when identified as a co-dependent.

Most bases of any size have a discrete Family Advocacy Program. This resource exists as a visible point of contact for family who are experiencing any sort of problem. Program personnel are trained to be aware of the high correlation between such problems as physical or sexual abuse and heavy alcohol or drug use. Many problems resulting from or in the presence of alcoholism and drug abuse are first identified through the Family Advocacy Programs, which then make referrals as necessary and appropriate. Providers in our medical facilities, particularly emergency room personnel and primary care providers, are encouraged to be aware of the possible role of alcohol or drug use in the cases they see. We are presently attempting to expand our External Civilian Peer Review Program to monitor emergency room visits and analyze them for possible indications of alcohol and drug abuse and child or spouse abuse. This will give us an additional focus in shaping our response to better serve and protect these populations.

CHILDREN

While many of the children of military personnel are involved in and benefiting from the same programs and influences as their civilian counterparts, many are in a situation which imposes an obligation on DoD to structure a specific response. One of these is the Department of Defense Dependents Schools (DoDDS).

In addition to a K-12 curriculum for drug education, the DoDDS program includes drug awareness activities and contests, cross-age and peer teaching, and inservice training of teachers and administrators. Additionally, forty-two schools have been involved in the DARE program developed by the Los Angeles Unified School District and the Los Angeles Police Department in 1983. An additional forty sites will be added in the school year 1989-90. By then, over 150 military police officers will have been trained in the DARE program.

DoDDS also has a Drug Free Workplace policy. Implementation includes education, applicant and employee testing, and counseling.

Because of the paucity of acceptable adolescent treatment resources in Europe, a program was initiated in late 1987 to place

teams of outpatient adolescent substance abuse treatment specialists in several locations. These teams provided support for and accepted referrals from DoDDS, Family Advocacy Programs, and Military Treatment Facilities. Because of the need of some adolescents for an initial residential treatment regimen, we have recently approved the reprogramming of CHAMPUS funds to develop a residential adolescent alcohol and drug treatment unit at the Army hospital at Badd Cannstadt, Germany. These programs all require the participation of the parents in the treatment of the adolescent.

CONCLUSION

Mr. Chairman, while we have certainly not eradicated the scourge of alcohol and drug abuse among the populations entrusted to us for care, we have attempted to target our limited health and education dollars in a manner to effect the greatest reduction in the impact of these problems among our military men and women and their families. I would be pleased to answer any questions you may have.

STATEMENT

JAMES N. FORSBERG

COORDINATOR, SPECIAL-NEEDS ASSISTANCE PROGRAMS
OFFICE OF THE ASSISTANT SECRETARY FOR COMMUNITY
PLANNING AND DEVELOPMENT
DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Before The
Governmental Affairs Committee
United States Senate

July 31, 1989

MR. CHAIRMAN, MY NAME IS JAMES FORSBERG AND I AM THE COORDINATOR OF THE SPECIAL-NEEDS PROGRAMS, THAT IS, THE HOMELESS PROGRAMS, IN THE OFFICE OF THE ASSISTANT SECRETARY FOR COMMUNITY PLANNING AND DEVELOPMENT, OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT. SECRETARY KEMP HAS ESTABLISHED ENDING THE TRAGEDY OF HOMELESSNESS AS ONE OF THE DEPARTMENT'S PRIORITIES. WE ARE CURRENTLY UNDERGOING A REORGANIZATION IN THE DEPARTMENT TO BETTER ACHIEVE THIS OBJECTIVE BY CONSOLIDATING THE RESPONSIBILITY FOR ALL OF THE MCKINNEY ACT HOMELESS ASSISTANCE PROGRAMS, EXCEPT FOR THE SECTION 8 SINGLE ROOM OCCUPANCY PROGRAM, IN THE OFFICE OF THE ASSISTANT SECRETARY FOR COMMUNITY PLANNING AND DEVELOPMENT. THIS CONSOLIDATION OF PROGRAMS IS DESIGNED TO HELP IMPROVE THE DELIVERY OF THE OF MCKINNEY PROGRAMS THE DEPARTMENT ADMINISTERS - TO ENSURE CONSISTENT AND COMPLEMENTARY POLICIES ACROSS THE SPECTRUM OF PROGRAMS, TO ENSURE THE PROGRAMS ADDRESS THE FULL ARRAY OF NEEDS OF THE HOMELESS AND TO MAKE THE PROGRAMS TRULY RESPONSIVE TO THE NEEDS OF THE HOMELESS.

WHEN JACK KEMP FIRST BECAME SECRETARY OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT HE VISITED INNER CITIES ACROSS THE NATION TO SEE THE CHALLENGES WE FACE AS WE WORK TO CREATE JOB, OPPORTUNITIES AND DECENT, DRUG-FREE HOUSING FOR EVERY AMERICAN FAMILY. THESE VISITS POINTED TO A VERY TRAGIC FACT. IN PUBLIC HOUSING PROJECTS THROUGHOUT THE COUNTRY DRUG ABUSE AND DRUG DEALING ARE THREATENING THE HEALTH AND SAFETY OF THE RESIDENTS AND UNDERMINING THE DEPARTMENT'S ABILITY TO APPROPRIATELY MANAGE

THESE PROGRAMS. WE INTEND AT HUD TO DO EVERYTHING POSSIBLE TO SUPPORT THOSE HOUSING AGENCIES AND TENANT MANAGERS WHO ARE DETERMINED TO RID THEIR COMMUNITIES OF THE SCOURGE OF DRUGS. THE SECRETARY'S OTHER RESIDENT INITIATIVES, RESIDENT MANAGEMENT, HOMEOWNERSHIP AND ECONOMIC DEVELOPMENT WILL HAVE A POSITIVE IMPACT ON THE PROBLEM OF DRUG ABUSE IN PUBLIC HOUSING. TOGETHER WITH BILL BENNETT AND ATTORNEY GENERAL THORNBURGH, SECRETARY KEMP HAS DEVELOPED A 10 POINT PROGRAM TO FIGHT DRUGS IN PUBLIC HOUSING.

- o TIGHTENING SECURITY WITH EFFORTS SUCH AS QUICKLY EVICTING ILLEGAL TENANTS, FURNISHING LEGITIMATE RESIDENTS WITH I.D. CARDS, REPAIRING PUBLIC AREAS AND TRAINING GUARDS.

- o WAIVING UNNECESSARY FEDERAL LEASE AND GRIEVANCE RULES TO EVICT TENANTS ENGAGED IN ILLEGAL DRUG ACTIVITIES. HUD ALREADY HAS MADE 29 DETERMINATIONS, AND DOES NOT WANT TO IMPEDE THE EVICTION OF DRUG CRIMINALS FROM PUBLIC HOUSING PROJECTS BY REQUIRING DUPLICATIVE ADMINISTRATIVE LEASE AND GRIEVANCE PROCEEDINGS WHEN DUE PROCESS PROTECTIONS ARE FULLY AFFORDED BY STATE OR LOCAL LAW.

SECRETARY KEMP HAS ASKED THE CONGRESS TO REPEAL SECTION 404 OF THE SUPPLEMENTAL APPROPRIATIONS BILL TO ALLOW THESE EFFORTS TO CONTINUE.

- o ASKING U.S. ATTORNEYS TO SEIZE APARTMENTS OF DRUG DEALERS AND USERS AND RETURN THEM TO LEGITIMATE LAW ABIDING TENANTS.
- o RECLAIMING VACANT UNITS FOR LEGITIMATE PURPOSES AND DENYING DRUG DEALERS ACCESS TO SUCH UNITS.
- o ENFORCING HOUSING CODE STANDARDS.
- o ENCOURAGING RESIDENT MANAGEMENT AND HOMEOWNERSHIP EFFORTS. THE SECRETARY HAS ASKED KIMI GRAY OF THE KENILWORTH-PARKSIDE PROJECT AND OTHER TENANT MANAGEMENT LEADERS TO TOUR WITH HIM AND TEACH RESIDENTS HOW TO REMOVE DRUG DEALERS AND MANAGE PROJECTS.
- o ESTABLISHING AN ANTI-DRUG HOTLINE AT HUD FOR RESIDENTS TO REPORT DRUG-RELATED CRIMINAL ACTIVITY IN CONFIDENCE.
- o TERMINATING IMMEDIATELY ELIGIBILITY FOR SEC. 8 RENT VOUCHERS OR CERTIFICATES OF PERSONS CONVICTED OF DRUG CRIMES AND BARRING THEM FROM OTHER SUBSIDIZED HOUSING.

- o USING THE DRUG ELIMINATION PILOT PROGRAM, CIAP MODERNIZATION FUNDS AND OPERATING SUBSIDIES TO SUPPORT ANTI-DRUG EFFORTS.
- o SUPPORTING ORGANIZED RECREATIONAL ACTIVITIES FOR THE YOUTH OF PUBLIC HOUSING. SECRETARY KEMP BELIEVES THAT THERE SHOULD BE BASEBALL AND FOOTBALL TEAMS IN EVERY PUBLIC HOUSING PROJECT. HE IS CONVINCED THAT PROVIDING ALTERNATIVES TO YOUTH HAVE A SIGNIFICANT IMPACT UPON PUTTING AN END TO THE SCOURGE OF DRUG TRAFFICKING.

MR. CHAIRMAN, AS WE AGGRESSIVELY PURSUE OUR OBJECTIVES TO ERADICATE DRUGS FROM OUR HOUSING PROGRAMS WE WILL NOT DO SO AT THE EXPENSE OF INDIVIDUAL TENANTS' RIGHTS. I WANT TO REASSURE THIS COMMITTEE THAT WE WILL CARRY OUT OUR EVICTION POLICY ON A CASE-BY-CASE BASIS WITH COMPASSION AND CONSIDERATION FOR INNOCENT VICTIMS. KINSHIP AND ASSOCIATION ARE NOT AUTOMATIC GROUNDS FOR ANYONE'S EVICTION. IN HIS RECENT NOTICE IMPLEMENTING PROVISIONS OF THE 1988 ANTI-DRUG ABUSE ACT SECRETARY KEMP GAVE VERY EXPLICIT GUIDANCE THAT THE ACT "DOES NOT RESTRICT THE PUBLIC HOUSING AUTHORITIES' [FROM EXERCISING] WISE AND HUMANE JUDGMENT, WEIGHING THE INTERESTS OF ALL CONCERNED."

WHEN CONSIDERING ACTION AGAINST RESIDENTS INVOLVED IN DRUGS, PUBLIC HOUSING AUTHORITIES HAVE THE DISCRETION TO WEIGH THE SERIOUSNESS OF THE OFFENSE, THE PARTICIPATION BY OTHER FAMILY MEMBERS, THE SITUATION AT THE PROJECT IN QUESTION, AND THE EFFECTS OF EVICTION ON THE OTHER FAMILY MEMBERS.

FURTHERMORE, NO TENANT MAY BE EVICTED WITHOUT THE OPPORTUNITY FOR A FAIR HEARING IN COURT. YOU CAN BE SURE THAT EACH OF OUR TENANTS WILL BE PROVIDED ALL THE PROTECTIONS THAT DUE PROCESS AFFORDS SO THAT THE LEGAL RIGHTS OF ALL ARE GIVEN FULL PROTECTION.

ADDITIONALLY, WE ARE CONCERNED WITH DRUG ABUSE AND ITS RELATIONSHIP TO HOMELESSNESS. DRUG ABUSE IS EMERGING AS ONE OF THE MAJOR CAUSES OF HOMELESSNESS. IN A RECENT ARTICLE IN THE NEW YORK TIMES, ONE ASSISTANCE PROVIDER ESTIMATED THAT 75 TO 80 PERCENT OF HOMELESS MEN AND WOMEN ARE ADDICTS. ROBERT HAYES, DIRECTOR OF THE NATIONAL COALITION FOR THE HOMELESS, SAYS "DRUG TREATMENT IS AT LEAST AS IMPORTANT AS HOUSING FOR THE HOMELESS." NATIONAL STUDIES INDICATE THAT ABOUT ONE THIRD OF THE HOMELESS SUFFER FROM ALCOHOL OR DRUG ABUSE, AND A THIRD FROM MENTAL DISABILITIES. WHILE THESE TWO GROUPS DO OVERLAP TO SOME EXTENT, MOST RESEARCHERS AGREE THAT SOMEWHERE BETWEEN 40-50 PERCENT OF THE HOMELESS SUFFER FROM ONE OR BOTH OF THESE AFFLICTIONS. REGARDLESS OF WHICH NUMBERS ONE USES, IT IS CLEAR THAT WE ARE FACING A

PROBLEM OF MAJOR PROPORTIONS. WE MUST DETERMINE WHAT MEANS -- BOTH SHELTER AND SERVICES -- ARE MOST USEFUL TO ENABLE THE HOMELESS TO MOVE TO SELF SUFFICIENCY AND INDEPENDENT LIVING.

IN RECENT TESTIMONY BEFORE THE HOUSE SELECT COMMITTEE ON THE AGING, SECRETARY KEMP EMPHASIZED THE VALUE IN CERTAIN INSTANCES IN LINKING HOUSING WITH SUPPORTIVE SERVICES. OUR GOAL IN ADMINISTERING THE MCKINNEY HOMELESS PROGRAMS IS TO ENSURE THAT THE HOMELESS RECEIVE THE SUPPORTIVE SERVICES THEY REQUIRE.

UNDER THE MCKINNEY ACT, THE DEPARTMENT CURRENTLY ADMINISTERS THREE PROGRAMS WHICH ARE RESPONSIVE TO THE PROBLEMS YOU ARE ADDRESSING HERE TODAY - THE EMERGENCY SHELTER GRANTS PROGRAM, THE TRANSITIONAL HOUSING PROGRAM, AND THE PERMANENT HOUSING FOR THE HANDICAPPED (BOTH PHYSICALLY AND MENTALLY) HOMELESS. AS THEIR NAMES SUGGEST, THESE PROGRAMS REPRESENT A CONTINUUM OF HOUSING RESOURCES TO MEET A VARIETY OF NEEDS. IN ADDITION TO THESE THREE PROGRAMS, PRESIDENT BUSH'S BUDGET HAS ALSO SOUGHT FUNDING FOR ANOTHER PROGRAM AUTHORIZED BY THE MCKINNEY ACT, BUT ONLY FUNDED IN 1987, THE SUPPLEMENTAL ASSISTANCE FOR FACILITIES TO ASSIST THE HOMELESS PROGRAM. THIS PROGRAM IS DESIGNED TO CREATE INNOVATIVE, COMPREHENSIVE APPROACHES TO MEET THE IMMEDIATE AND LONG TERM NEEDS OF THE HOMELESS. MOST IMPORTANTLY, HOWEVER, EACH OF THESE PROGRAMS INCLUDES A SUPPORTIVE SERVICE ELEMENT TO ADDRESS THE NON-HOUSING NEEDS OF THE HOMELESS. I MIGHT ADD THAT PRESIDENT BUSH

AND SECRETARY KEMP ARE ALSO SEEKING AN ADDITIONAL APPROPRIATION OF \$50 MILLION IN 1990 FOR A NEW INITIATIVE - - COMPREHENSIVE SHELTER AND SERVICES PROGRAM -- WHICH WOULD PROVIDE AN OPPORTUNITY FOR STATES, LOCAL GOVERNMENTS AND NON-PROFITS TO DEVELOP COMPREHENSIVE PROGRAMS TO ADDRESS THE MOST CRITICAL LOCAL NEEDS. THE PROGRAM WOULD REQUIRE THE INVOLVEMENT OF THE PRIVATE AND NON-PROFIT SECTORS, AS WELL AS THE LOCAL PUBLIC SECTOR.

NOT ONLY DOES EACH OF THE PROGRAMS PROVIDES FINANCIAL ASSISTANCE FOR SUPPORTIVE SERVICES, EACH REQUIRES THAT A PORTION OF THE COST BE PROVIDED FROM OTHER SOURCES, WHICH PROMOTES COORDINATION OF SERVICES WITH THOSE OF OTHER LOCAL PROVIDERS. EACH PROGRAM ALSO REQUIRES THAT THERE BE AN ONGOING ASSESSMENT OF THE SUPPORTIVE SERVICE NEEDS OF RESIDENTS TO ENSURE THE SERVICES TO BE PROVIDED ARE TRULY RESPONSIVE TO THE NEEDS OF THE RESIDENTS. TWO OF THE PROGRAMS, TRANSITIONAL HOUSING AND THE SUPPLEMENTAL ASSISTANCE FOR FACILITIES TO ASSIST THE HOMELESS, HAVE AS A PRIORITY THE PROVISION OF ASSISTANCE TO HOMELESS FAMILIES WITH CHILDREN.

EVEN THOUGH SUPPORTIVE SERVICES ARE PERMITTED, NEITHER THE MCKINNEY ACT NOR HUD, THROUGH ITS REGULATIONS, PRESCRIBES THE TYPE OF SUPPORTIVE SERVICES TO BE PROVIDED. THE PROGRAMS DO PROVIDE MAXIMUM DISCRETION TO LOCAL GOVERNMENTS AND PROVIDERS TO USE THESE RESOURCES IN A MANNER MOST RESPONSIVE TO LOCAL NEEDS, AND

ENSURES THE FUNDS CAN BE USED TO FILL THOSE GAPS IN EXISTING SERVICES WHICH ARE PROVIDED THROUGH OTHER RESOURCES. WE BELIEVE FLEXIBILITY IS ESSENTIAL TO ENSURE THE FUNDS ARE USED AS EFFECTIVELY AS POSSIBLE.

WE MUST REALIZE THAT MANY HOMELESS HAVE MULTIPLE PROBLEMS, SUCH AS DRUG ADDICTION, MENTAL ILLNESS, HEALTH AND NUTRITIONAL ISSUES, SOCIAL DYSFUNCTIONS, OR LACK BASIC COPING SKILLS, ALL OF WHICH NEED TO BE ADDRESSED. IT IS ALSO CRITICAL TO RECOGNIZE THAT THE PROBLEM, OR PROBLEMS, EXIST TO VARYING DEGREES IN DIFFERENT LOCALITIES, AND THE RESOURCES AVAILABLE TO ADDRESS THE PROBLEMS ALSO VARY SUBSTANTIALLY. THUS, THERE IS NO SINGLE ANSWER OR SOLUTION THAT THE FEDERAL GOVERNMENT CAN PROVIDE. RATHER, WE NEED TO PROVIDE THE FLEXIBILITY TO UTILIZE FEDERAL RESOURCES IN A MANNER MOST RESPONSIVE TO LOCAL NEEDS, RESOURCES AND STRATEGIES.

TO GIVE YOU AN IDEA OF HOW OUR PROGRAMS ARE USED, LET ME PROVIDE YOU WITH SOME OF THE RESULTS. THESE ARE NOT COMPLETE BECAUSE WE DON'T HAVE ALL THE DATA TO PROVIDE A COMPLETE PICTURE, BUT IT DOES REPRESENT TYPICALLY HOW THE FUNDS ARE USED. IN THE TRANSITIONAL HOUSING PROGRAM IN 1987 AND 1988, OVER \$115 MILLION

IN ASSISTANCE WAS PROVIDED. OF THAT AMOUNT, \$97 MILLION (OR 84%) WAS USED FOR OPERATING COSTS, OF WHICH SUPPORTIVE SERVICES ARE PART. THIS FIGURE REPRESENTS THE AMOUNT OBLIGATED TO PROVIDE OPERATING COSTS OVER A FIVE YEAR PERIOD. IF WE LOOK AT ONLY ONE YEAR, OVER 52 PERCENT (\$19 MILLION) WAS USED FOR OPERATING COSTS. OBVIOUSLY, THESE FUNDS ARE BEING USED TO ADDRESS THE SUPPORTIVE SERVICE NEEDS OF THE HOMELESS. NOTE ALSO THAT OF THE 230 PROJECTS FUNDED, 100 WERE FOR FAMILIES WITH CHILDREN, REPRESENTING 30 PERCENT OF THE TOTAL FUNDS (\$41 OF THE \$115 MILLION).

AS A PART OF THE TRANSFER OF THESE PROGRAMS TO THE OFFICE OF THE ASSISTANT SECRETARY FOR COMMUNITY PLANNING AND DEVELOPMENT, WE ARE CONDUCTING A THOROUGH REVIEW OF ALL EXISTING REGULATIONS TO ELIMINATE UNNECESSARY REQUIREMENTS WHICH MAKE IT DIFFICULT FOR MANY OF THE NON-PROFIT SERVICE PROVIDERS TO USE THE PROGRAMS. THIS IS CRITICAL TO THE SUCCESS OF OUR EFFORTS TO END THE TRAGEDY OF HOMELESSNESS BECAUSE ALMOST 90 PERCENT OF THE PROVIDERS ARE NON-PROFITS WITH SCARCE RESOURCES AND HAVE DIFFICULTY COPING WITH ONEROUS FEDERAL REQUIREMENTS.

I WANT TO NOTE THE INTERAGENCY COUNCIL ACTIVITIES RELATED TO ADDRESSING ALCOHOL AND DRUG ADDICTION PROBLEMS OF WOMEN AND THEIR CHILDREN. AS YOU KNOW, UNDER THE LEADERSHIP OF SECRETARY KEMP AND SECRETARY SULLIVAN, THE COUNCIL HAS BEGUN A NUMBER OF INITIATIVES TO HELP COORDINATE THE DELIVERY OF MCKINNEY ACT RESOURCES.

- o THE INTERAGENCY COUNCIL ISSUES A BULLETIN CALLED THE PROGRAM ALERT WHICH CONTAINS TIME-SENSITIVE INFORMATION ON FEDERAL FUNDING, REGULATORY AND OTHER VITAL PROGRAM ACTIVITIES RELEVANT TO SERVING THE HOMELESS. THE COUNCIL SENDS THIS BULLETIN TO PROVIDERS AS WELL AS OTHER INTERESTED GROUPS ACROSS THE COUNTRY.

A NUMBER OF THESE ANNOUNCEMENTS PROVIDE VITAL INFORMATION ABOUT PROGRAMS THAT CAN ASSIST ALCOHOL AND SUBSTANCE ABUSE PROBLEMS. AN EXAMPLE IS A FUNDING ANNOUNCEMENT FOR THE HEALTH CARE FOR THE HOMELESS PROGRAM CONTAINED IN A PROGRAM ALERT THAT WAS ISSUED LAST WEEK. THIS DHHS PROGRAM PROVIDES FOR THE DELIVERY OF PRIMARY HEALTH SERVICES AND SUBSTANCE

ABUSE SERVICES IN BOTH URBAN AND RURAL AREAS. THE ANTICIPATED FY 1990 FUNDING LEVEL IS \$63.6 MILLION.

- o THE COUNCIL ALSO SPONSORS REGIONAL WORKSHOPS, AS REQUIRED BY THE MCKINNEY ACT. EARLIER THIS MONTH, SUCH A WORKSHOP WAS HELD IN ATLANTA, AND WAS ATTENDED BY MORE THAN 450 PROVIDERS AND OTHERS. AMONG THE VARIOUS ISSUES ADDRESSED AT THE TWO-DAY WORKSHOP WAS SUBSTANCE ABUSE. ONE OF THE PRESENTERS WAS BARBARA LUBRAN FROM DHHS WHO DESCRIBED THE FEDERAL RESOURCES, INCLUDING THE COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANTS, THAT COULD BE USED BY PROVIDERS FOR DRUG AND ALCOHOL ABUSE TREATMENT SERVICES.

- o A MORE GENERAL CONTRIBUTION OF THE COUNCIL TO ADDRESSING THE ALCOHOL AND SUBSTANCE ABUSE IS COUNCIL AGENCIES' EFFORTS TO ELIMINATE PROGRAMMATIC BARRIERS CAUSED BY CONFLICTING RULES, REQUIREMENTS, DEFINITIONS, ETC. UNDER THE AUSPICES OF THE COUNCIL, A SERIES OF MEETINGS BETWEEN HHS AND HUD HAVE BEGUN TO LOOK AT BARRIERS AND TO MINIMIZE EXCESSIVE AND UNNECESSARY PAPER WORK. GIVEN THE CLOSE RELATIONSHIP BETWEEN THE HUD MCKINNEY PROGRAMS, WHICH ARE FOCUSSED ON PROVIDING FACILITIES AND RELATED SUPPORTIVE SERVICES, AND THE HHS MCKINNEY PROGRAMS, WHICH ARE FOCUSSED ON PROVISION OF SUPPORTIVE SOURCES, WE VIEW THIS COORDINATION AS CRUCIAL TO EFFECTIVE DELIVERY OF RESOURCES.

HUD HAS A VAST ARRAY OF PROGRAMS TO HELP IN THE FIGHT AGAINST HOMELESSNESS AND DRUG ADDICTION AND ABUSE. AS I SAID WE ARE LOOKING AT THOSE PROGRAMS TO ELIMINATE ANY BARRIERS WE MAY HAVE INADVERTENTLY CREATED, AND WE ARE WORKING WITH HEALTH AND HUMAN SERVICES TO IDENTIFY COMMON ISSUES FACED BY BOTH PROGRAMS TO IDENTIFY WAYS IN WHICH WE CAN ENSURE OUR PROGRAMS ARE SUPPORTIVE OF OUR COMMON GOAL AND NOT GENERATING PROBLEMS AND DILEMMAS FOR THOSE WHO USE OUR PROGRAMS. WE NEED TO ENSURE THE PROGRAMS HELP CARRY OUT, TO THE EXTENT POSSIBLE, THE OBLIGATION WE AS A SOCIETY HAVE TO HELP THOSE WHO ARE MOST VULNERABLE AND WHO NEED OUR HELP TO BECOME SELF SUFFICIENT AND LEAD FULL PRODUCTIVE LIVES.

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